

The RHODE ISLAND MEDICAL JOURNAL

VOL. XLII

NOVEMBER, 1959

NO. 11

STAPHYLOCOCCIC PULMONARY INFECTIONS*

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IN RECENT YEARS many new and effective agents have been introduced to kill the bacteria which exist in our communities. With these powerful weapons, however, comes an increased responsibility. The infection has to be correctly identified and the proper antibiotic must be given for an adequate length of time. In the case of pneumococcal infections, recognition is relatively easy and a specific cure, penicillin, is available. On the other hand, in severe staphylococcic infections, recognition may be missed or dangerously delayed and protection by the covering antibiotic absent because of previous use of the chosen antibiotic. This has been particularly true in cases involving penicillin and streptomycin administration.

In a recent personal experience in a large hospital, more than 40 cases of antibiotic-resistant staphylococcic pneumonia, principally due to a hospital acquired strain, were diagnosed and treated during a two-year period.¹ They may be categorized as occurring in the following manner:

(a) Complication of pre-existing major disease—Metastatic carcinoma, lymphoma, etc.

(b) Post-influenzal.

(c) Post-operative—*Key personnel*, medical, surgical or nursing may harbor pathogenic strains and/or lesions (boils, etc.) and should be screened carefully to control these accidents.

(d) In apparently healthy hospital personnel.

In our staff, 1 medical officer, 1 nurse, and 5 corpsmen fell victim to staphylococcic pneumonia, emphasizing the communicable disease aspect of this problem. In some cases a mild "flu-like" illness had been a forerunner.

*Presented at the Interim Meeting of the Rhode Island Medical Society at the U.S. Naval Air Station, Quonset, Rhode Island, September 23, 1959.

Opinions expressed are those of the author and do not necessarily reflect those of the Navy Department.

A considerable number of staphylococcic infections, both postoperative and otherwise, were present in the hospital at this time. *Case 1:* Attention was focused sharply on the widespread and urgent character of this problem when one of our young staff hospitalmen was stricken. He had suffered from a cold and resorted to self-medication during a three-week period, using several antibiotics. His fiancée, a Wave corpsman, was hospitalized for furunculosis. He had then been exposed to a patient with staphylococcic pneumonia and soon after was admitted to the sick list with pleuritic pain and signs of pneumonia. Chest roentgenogram in the morning was interpreted as being essentially negative. A repeat film that same afternoon revealed an extensive infiltration in the right base. By the following morning roentgenographic findings revealed areas of consolidation and infiltration involving the entire right lung with extensive involvement of the left lung. A positive blood culture yielded coagulase positive staphylococcus aureus, phage type 52-42B-80/81, the so-called "hospital strain." His rapid shocking death occurred on the third hospital day, despite heroic measures. This event served to provoke action as outlined in Table I.²

TABLE I

Task Force Staphylococcus

- I. Antibiotic Control Board—3 agents were restricted and withheld for use in specific infections. They were chloramphenicol, novobiocin and ristocetin and were believed to be effective against our particular hospital strain.
- II. Pneumonia Team (see below).
- III. Epidemiology Center—A collecting center of information for co-ordinating the attack.

The Pneumonia Team consisted of 4 medical officers who stood a telephone watch and were available as consultants around the clock. Whenever a patient suspected of pneumonia was admitted, the medical officer got in touch with a member of the Pneumonia Team and discussed the general problem, the bacteriology of the sputum and the radiologic changes. In this manner a constant high level of clinical suspicion of staphylococcic pneumonia was maintained. The theme of this operation was "do it yourself," for the admitting doctor collected

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and examined the sputum, interpreted his patient's X-ray films and sought consultation at the earliest opportunity. Diagnosis was made earlier and treatment was standardized; tracheostomy was performed in 21 cases, both as a precautionary and as an emergency procedure. These factors are believed to have contributed significantly in curbing the mortality rate in this series. The following outline served as a useful guideline.

U.S. Naval Hospital
St. Albans, New York

15 October 1957

Rationale for Pneumonia Therapy

1. DIAGNOSIS

- a) Sputum examination—done by medical resident personally.
- b) Blood culture; blood counts.
- c) Roentgenograms, as indicated—study your patient's X rays.
- d) History and physical examination.
- e) Antibiotic sensitivity tests.
- f) WBC, T.I.W. especially with ristocetin and chloramphenicol.

2. THERAPY — Contact "Pneumonia Team" (Telephone Watch)

a) *Selective therapy*, when indicated, i.e. penicillin-resistant pneumococci are practically unknown... *pneumococcal pneumonia* is effectively treated by penicillin alone.

b) *Gamma Globulin* 10 cc I.M. every other day; 20 cc as first dose; purportedly acts to potentiate process of phagocytosis and mobilize host resistance (in fulminant infections).

c) *Staphylococcal Pneumonia* is a distinct disease with unusual and formidable characteristics. Local experience has been extensive in treating this condition. Contact "Pneumonia Watch" for guidance in antibiotic therapy for each case. There are at least two reliable antibiotics reserved for the seriously involved patient (ristocetin and chloramphenicol).

d) *Atypical (P.A.P.) Pneumonias* of viral origin do not ordinarily require antibiotic therapy when uncomplicated.

3. GENERAL CONSIDERATIONS

a) Prophylaxis for "complications" is no indication for antibiotic use in the viral pneumonias.

b) Focus "on target"; select the proper arrow from your quiver and hit hard. There is a strong case for narrow spectrum antibiotics in therapy; the case against wide-spectrum antibiotics grows stronger.

4. NavHosp Instruction 6710.1—Subj: Dangerous Drugs, Automatic Stop-Order of 1 July 1957.

a) Compliance with above will be observed by "flagging" antibiotic and other dangerous drug

orders and renewing same on Monday, Wednesday and Friday of each week.

b) The nurse will not stop any dose, however, without notifying the medical officer.

/s/ CHIEF OF MEDICINE

Hemolytic, coagulase-positive staphylococcal pneumonia may present as a fulminant process with death occurring before bacteriological proof can be obtained. In such instances, as Case 1, massive doses of intravenous bactericidal antibiotics should be given while awaiting bacteriological confirmation. Sputum may not be obtainable at the onset of fulminant dissemination because of its tenacious, thick consistency. The following case highlights the multiple complications and therapeutic frustrations that may attend a fulminant disseminated infection.³

Case 2: A 21-year-old white man was referred to the Medical Service because of pneumonia, etiology undetermined. History revealed that he had sustained a fracture of the second cervical vertebra in an automobile accident. Treatment had consisted of "prophylactic penicillin and streptomycin" and tong traction. While he was receiving these antibiotics, a secondary infection of the scalp became evident. The patient developed generalized urticaria and penicillin was stopped. Two days later he developed a fever of 106 F. and a nonproductive cough. The patient was then started on intravenous oxytetracycline, 500 mg. twice daily, with no effect. Roentgenogram of the chest revealed a right upper lobe pneumonia. Intravenous oxytetracycline was continued for two days, during which time the patient deteriorated rapidly. When received on the Medical Service he was semicomatose and cyanotic.

A tracheostomy was performed and the aspirate cultured out hemolytic staphylococcus, coagulase-positive. A culture of the scalp infection and blood cultures revealed the same organism. Chloramphenicol, 500 mg. every four hours, was started by mouth (before the culture reports were obtained), during which time the patient's condition worsened with rapid appearance of left ventricular failure and cyanosis. Intravenous sulfadiazine, 3.75 Gm. every 12 hours, was started; rapid digitalization and phlebotomy were performed, respiratory support was maintained by a Drinker respirator. During the next three days, temperature dropped by lysis and objective improvement was evident; however, on the fourth day fever of 105 F. and semicoma recurred. Sensitivity studies on the previously obtained material for culture revealed in vitro sensitivity to chlortetracycline, bacitracin, chloramphenicol, erythromycin, nitrofurantoin, neomycin, tetracycline hydrochloride, and novobiocin. In vitro, resistance was found to dihydrostreptomycin, penicillin, polymyxin B, oxytetracycline, and sulfadiazine. Erythromycin, 200 mg. every four hours intra-

muscularly, and chlortetracycline, 500 mg. every six hours, by nasogastric tube were administered with a drop of temperature to 102 to 103 F., remaining at this level. Under this regimen however, the pneumonic process extended to involve the entire right lung and the left upper lobe.

On the fifth day of this phase of the regimen, the patient had a right spontaneous pneumothorax with resulting pyothorax and open bronchopleural fistula. Subsequent antibiotics and chemical agents consisted of combinations of novobiocin, sulfadiazine, erythromycin, and streptomycin, during which time the patient developed a persistent tachycardia of 150, pericardial friction rub, electrocardiographic evidence of pericarditis, fixed specific gravity of urine, and continuous albuminuria. Fever continued between 102 and 103 F. and the spleen became palpable. A full-blown septicemia was rampant at this time.

All findings remained static until ristocetin, 1000 mg. initially and 250 mg. every six hours, was started intravenously in combination with the previously mentioned antibiotics. Ristocetin was continued with a gradual tapering in dosage for 12 days, at which time fever dropped by lysis. Evidence of pericarditis disappeared, the spleen was no longer palpable, blood cultures became negative, dissemination of the pneumonic process appeared to be arrested with localization of empyema pockets amenable to thoracentesis and closure of the bronchopleural fistula. Rapid subjective and objective improvement of the patient ensued. Ristocetin was discontinued after 12 days with no recurrence of fever, and the patient was maintained on oral novobiocin, 500 mg. every six hours, for the next two months. (This was the first local experience with ristocetin and little information was available as to its toxicity, thus the discontinuance at 12 days. Twenty-five additional cases have been treated since then for periods up to 2 months without serious reaction. A case similar to the above would now be continued on this therapy.)

Comment

This case demonstrates the gravity of a hospital-acquired staphylococcic pneumonia and its complications. Eighteen combinations of 10 different antibiotics and sulfadiazine were used with no apparent response except for transient response with sulfadiazine, to which resistance quickly occurred. Erythromycin and novobiocin were ineffective; however, when ristocetin was added rapid clinical improvement was noted. This man was returned to civilian life, fully recovered and is carrying on at full activity.

Early in this experience it became evident that there were radiologic characteristics peculiar to staphylococcic pneumonia, of high reliability in leading to diagnosis.

Radiologic Findings

Rapid Progression—in hours.

- I. Early—small patches of consolidation
- II. Infiltration c circumscribed translucencies
- III. Pleural Effusion
- IV. Typical—pneumatocoles
- V. Spontaneous tension pneumothorax
c or s empyema

Diagnostic features of history, physical findings and the patient's clinical appearance were utilized together with radiologic and bacteriologic findings to institute early decisive therapy.

Analysis of antibiotic sensitivities revealed most of the encountered organisms to be resistant to the sulfonamides, tetracyclines, streptomycin and penicillin.

Erythromycin enjoyed great popularity in the surrounding community, but it was ineffective in dealing with our severe staphylococcic infections. The best therapeutic results were obtained with chloramphenicol and intravenously administered ristocetin. Vigorous supportive therapy included tracheostomy. Gamma globulin was administered to 16 patients as adjunctive therapy.

A recent excellent report by Ede, Davis, and Holmes⁴ emphasized early surgical therapy for complications. Pulmonary complications encountered in our experience were pneumothorax, empyema, lung abscess and tension cysts. Only two patients had significant respiratory disability after recovery.

During the past several years a flood of reports has appeared regarding hospital-acquired antibiotic-resistant staphylococcic infections. The following table lists known biologic characteristics of the staphylococcus which help explain its formidable nature.

Some Biological Properties of the Pathogenic Staphylococci

1. Toxins and Lysins:

- a. Lethal toxin (potent; associated with certain hemolysins)
- b. Enterotoxin (potent toxin acting primarily upon GI tract)
- c. Dermonecrotic toxin (necrotizing toxin); hemolysins?)
alpha_{1,2}
- d. Hemolysin (alpha, beta, gamma, delta; rbc lysins)
- e. Fibrinolysin (dissolves fibrin clots; restricted essentially to coagulase-positive human strains)
- f. Leucocidin (destroys leucocytes)

2. Enzymes:

- a. Coagulase. This is regarded as *sine qua non* for pathogenicity (coagulates citated or oxalated plasma)

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- b. Hyaluronidase (attacks the mucopolysaccharide (hyaluronic acid) intracellular ground substance; "spreading factor")
- c. Staphylokinase (Plasminogen activator) (fibrinolysin?)
- d. Penicillinase. This is a notorious substance responsible for treatment failures (inactivates penicillin)

NOTE: Pathogenic, human (often of hospital origin), coagulase-positive staphylococci frequently belong to general phage Group III, types 80/81. These strains can further now be identified by fluorescent-antibody staining techniques.

One might reasonably pose the question, why does an antibiotic fail? In many instances it is apparent that antibiotic failure is blamed when a temperature fall has not been as rapid or as convincing as a physician would wish. A recent discussion with Dr. Monroe Romansky⁵ and a report by Alling and Pulaski⁶ have summarized *causes of failure* to include the following:

1. The use of antibiotics as substitutes for surgery. Fundamental surgical principles simply cannot be ignored, i.e., incision and drainage.
2. The causative organism not being sensitive to the antibiotic employed.
3. Presence of emerging strains of bacteria, resistant to the antibiotic.
4. Alteration of the bacteria flora during treatment (leading to superinfection).
5. Inaccessibility of the lesion so that the therapeutic agent cannot be brought into contact with it. Chronic infections, bony sequestra, and infections surrounded by a protective membrane are examples of this difficulty.
6. Inadequate dosage. In certain situations, low doses may actually stimulate the growth of bacteria; inadequate dosages may merely arrest the growth of the bacteria, whereas the indicated blood level of antibiotics would be bactericidal.
7. Too early withdrawal of therapy.

In general, when dealing with severe staphylococcal infections, a focus on target with a narrow spectrum antibiotic is recommended for best results. Success with ristocetin may be largely attributed to this factor.

Awareness of the manifestations and gravity of staphylococcal pneumonia, with attention to early diagnosis and decisive therapy, both medical and surgical, is to be emphasized as essential for the successful management of this disease.

Reversal of the attitude of complacency that has come to prevail during our enlightened antibiotic era is an urgent matter. Attention to fundamentals of asperis with more emphasis rather than less accorded this basic precept will surely go far in suppressing, if not eradicating, these infections.

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There is a long tradition of the physician's setting his own fees without having to explain to the Blue Shield or to an insurance company why a prolonged, complicated, and worrisome case merits a higher price tag. There is a natural resentment if the agent has sold the patient an inadequate type of policy, perhaps using deliberate deception as to the benefits. Among other worries which beset the private practitioner are the inroads made by closed-panel prepayment plans of labor groups, welfare funds, and the Veterans Administration. Here selected physicians are used, and freedom of the choice of other doctors is denied the insured. The threat of socialized government-controlled medicine is now a dark cloud on the physician's horizon. He is conscious of the plight of his brother physicians in England and Scandinavia. The recent landslide victory of the Conservative free-enterprise party in Britain indicates to him that the other great English-speaking country is fed up with socialism. The American doctor looks to insurance companies to provide a solution for the high cost of medical care through proper financing. He is beginning to realize that insurance helps his patient to pay his bills without attempting to dictate the type of care.

As physicians begin to appreciate our efforts to solve the problems of medical economics by health insurance prepayment plans, they look with particular favor on the major medical and comprehensive plans. In turn, we are educating them to the need for curbing abuses such as over-charging and the over-use of hospital facilities.

One of the greatest sources of irritation to the physician is the amount of paper work. For a single patient this can be cumulatively mountainous. Health evidence may be necessary not only for insurance and disability claims, but for birth, marriage, periodic check-ups, pre-employment, health problems at work, foreign travel, military service, retirement pension, and social security. Mindful of this patient's social and economic welfare, the modern physician must maintain good medical records. Obviously, anything we can do to ease his clerical burden is a godsend. As you know, we have made real progress in this respect in the development of uniform claim forms and in designing a simplified attending physician's statement to be used for his life insurance application. So far, 80% of the insurance companies have co-operated; with the help of the medical directors, we aim for an even higher figure.

...J. GRANT IRVING, M.D., *Chairman*, Medical Relations Committee, Health Insurance Council, in an address to the 68th annual meeting of the Association of Life Insurance Medical Directors of America, at New York, October 23, 1959.

COMBINED LEFT VENTRICULAR AND SUPRASTERNAL PERCUTANEOUS PUNCTURE IN ASSESSMENT OF MITRAL AND AORTIC VALVE DISEASE*

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RECENT ADVANCES in cardiovascular surgery have demonstrated the need for precise methods of evaluating altered function of the left heart. Direct needle puncture of the left ventricle, atrium and aorta makes possible the recording of pressure pulse tracings, as well as blood oxygen concentrations from these chambers, which are not ordinarily accessible to venous catheterization. When necessary, contrast media can be injected through the needle and the morphology of the left heart structures studied with the aid of serial X-ray films. Similarly, the injection of indicator dyes or radioactive isotopes and their subsequent recovery from the right heart or peripheral venous or arterial systems may provide additional useful information.

It is the purpose of this paper to review the history of left heart puncture, outline some of the techniques employed to obtain these physiologic data, present the technique we feel to be the safest and technically most satisfactory, and review our experience with six patients studied at the Rhode Island Hospital.

History

In 1953, Bjork¹ (Sweden) reported a method of percutaneously puncturing the left atrium from the back. A 20 cm. needle with a 1 mm. bore and 1.5 mm. outer diameter was introduced along the upper border of the right ninth rib 5 cm. to the right of the spinous process. Fluoroscopic examination and a typical pressure tracing confirmed the correct positioning of the needle within the left atrium. A thin polyethylene or polyvinyl catheter was then introduced through the needle into the left atrium. With manipulation, the catheter was passed through the mitral valve into the left ventricle and sometimes through the aortic valve into the ascending aorta. Reported complications of this procedure

were: rupture of intercostal artery causing a hemothorax, mild pneumothorax, hemopericardium, and pulmonary hemorrhage.

Puncture of the left atrium through the left main stem bronchus was developed by Allison & Linden in 1953² (England). After a bronchoscope was passed to the carina, a 5-6 cm. long, 0.3 cm. bore needle was introduced through the anteromedial wall of the left main stem bronchus and correctly positioned under fluoroscopic guidance. Although reported complications have been minimal, the disadvantage of this technique was that other left heart chambers could not be entered.

Percutaneous left ventricular puncture was developed and refined by Reboul and Racine,³ Ponsdomench and Nunez,⁴ and Smith, et al.,⁵ working first with dogs and subsequently with human subjects. In 1956, Sir Russell Brock⁶ reported his experiences with left lateral percutaneous puncture of the left ventricle in twenty-four patients without mortality or serious morbidity. Using this method in conjunction with retrograde aortic catheterization it was possible accurately to determine the gradient across the aortic valve. An 18-gauge needle was introduced directly through the chest wall 2 cm. below and lateral to the apex beat and advanced into the left ventricle pointing towards the second right costochondral junction with a backward inclination of 35°. In 1957, Lehman⁷ refined the technique of subxiphoidal percutaneous left ventricular puncture and reported his experience in seventy-seven patients. Although there is no mortality associated with this method, a significant number of patients accumulate a small amount of serosanguinous pericardial fluid which was found to be present at subsequent operation. Many patients complained of mild chest discomfort for several days.

Stig Radner⁸ (Sweden) in 1955 reported a method for serial entry of the aorta, pulmonary artery and left atrium with a long needle introduced percutaneously through the suprasternal notch. The safety of the suprasternal puncture with piercing of both main arterial trunks depended upon the fine caliber of needle used. Radner advised against using a needle larger than 0.8 mm. in outside diameter. In forty-nine patients who were studied by Radner, no serious complications were reported.

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Technique

At Rhode Island Hospital the technique employed for the study of the dynamics of the left heart has been derived with minor modifications from the combined methods of Lehman and Radner. Since the six patients reported here have been adults, a combination of 50 to 100 mg. Demerol and 0.1 gm. Nembutal has been administered one hour prior to the proposed procedure. All patients underwent routine right-heart catheterization through an arm vein to determine the cardiac output by the Fick Principle. At the completion of the right-heart catheterization the patients were further sedated by giving approximately 25 mg. of Demerol intravenously in preparation for the direct needle punctures. Local anesthesia (1% Procaine) was employed at the site of needle puncture. The patient was placed in a supine position with head extended and turned to the left. The suprasternal needle was connected through a three-way stopcock to a weak Heparin (50 mg. to 1000 cc. 5% D/W) drip and to a Sanborn pressure transducer and 4-channel Polyviso Recorder. It was then advanced through the suprasternal fossa at an angle predetermined from frontal and lateral chest roentgenograms so as to enter the aorta, pulmonary artery and left auricle serially (Figure 1). With the Radner needle in the left atrium, a 6-inch short-beveled #18-gauge needle was then inserted beneath the xiphoid cartilage and directed at a point halfway between the estimated position of the mitral valve and apex of the left ventricle. The right ventricle was usually entered first and the needle advanced further through the interventricular septum into the left ventricle (Figure 2). The location of each needle was checked by the characteristic pressure-pulse tracing obtained. Figure 3 illustrates the flexible #20-gauge suprasternal needle* and the #18-gauge

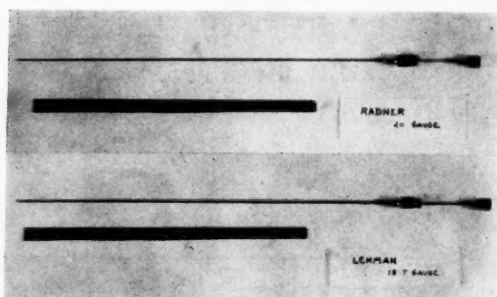


FIGURE III

#20 gauge suprasternal needle of Radner and #18 gauge ventricular needle of Lehman.



FIGURE IV

Both needles in position.

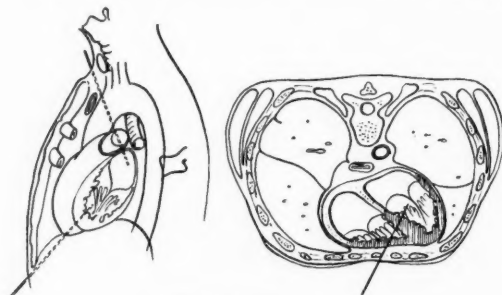
ventricular needle. Figure 4 demonstrates both needles in place. The electrocardiogram was continuously monitored throughout the procedure. With the needle in place, left auricular and left ventricular pressure-pulse tracings were obtained. The suprasternal needle was then withdrawn into the aorta so that simultaneous left ventricular and aortic pressure-pulse tracings were obtained.

Illustrative Cases

Case I

D.H.: A twenty-nine-year-old male carpenter had had a heart murmur since childhood. He had been refused life insurance and had been rejected from military service because of this murmur. One year before admission, he sustained a back injury in an automobile accident and developed complaints of easy fatigability, occasional tightness of the anterior chest, heartburn and symptoms of anxiety. Since that time he had been unable to work more than four hours per day.

Physical examination revealed a B.P. of 120/70 and a regular pulse rate of 68. The heart was not



FIGURES I and II

Radner's needle in place as it pierces the aorta, pulmonary artery and left auricle, and Lehman's needle, the tip of which is in the left ventricle.

Cross section of the thorax with the tip of the ventricular needle in the left ventricle, having pierced the right ventricle and septum.

*Made especially for us by the Becton and Dickenson Company.

enlarged. There was a harsh, Grade III, systolic murmur loudest at the base and transmitted into the neck vessels, over the precordium and to the upper back. A Grade I, early diastolic, decrescendo murmur was heard along the left sternal border. A-2 was greater than P-2. The electrocardiogram and roentgenograms of the chest were within normal limits. Left ventricular puncture revealed a pressure of 135/0. A pressure of 135/60 was recorded from the left brachial artery.

Since there was no systolic gradient across the aortic valve, this patient was felt to have insignificant aortic stenosis.

Case II

W.McC.: A twenty-three-year-old male had had known rheumatic heart disease since childhood. He had recently begun to complain of dyspnea after climbing two flights of stairs. Physical examination revealed a B.P. of 92/60 and a regular pulse rate of 84. His heart was enlarged to the left anterior axillary line. A-2 was diminished. There was a Grade III harsh, systolic aortic murmur with an associated thrill. The murmur was transmitted into the neck and anterior chest. A Grade III systolic murmur of somewhat different quality could be heard at the apex where there was a Grade II diastolic rumble. An opening snap was heard. Roentgenograms of the chest and chest fluoroscopy revealed left ventricular and left auricular enlargement. Electrocardiograms suggested right ventricular hypertrophy. Left-heart puncture revealed a systolic aortic gradient of 144 mm. Hg. The cross-sectional aortic valve area was calculated to be 0.4 sq. cm. Since 0.6 cm.² is considered to be the critical cross-sectional area, surgical correction of his lesions was advised. Several weeks later he developed auricular fibrillation. Subsequently, with the aid of a pump-oxygenator, he underwent open aortic and mitral valvulotomy with gratifying results.

Case III

G.M.: This eighteen-year-old male had had an aortic systolic murmur discovered four years before admission, although he gave no history of acute rheumatic fever. His only symptoms had been mild fatigue and minimal dyspnea and he had been doing strenuous manual labor. Physical examination revealed a B.P. of 110/70 and a regular pulse rate of 64. The heart was not enlarged. There was a harsh, Grade III, systolic aortic murmur heard well over the precordium and well transmitted into the neck vessels. A-2 was greater than P-2. The electrocardiogram was suggestive of left ventricular hypertrophy. Roentgenograms of the chest and chest fluoroscopy were normal. Left-heart puncture revealed a systolic aortic gradient of 90 and the cross-sectional aortic valve area was calculated to be 0.9 cm.²

This patient was considered to have moderate aortic stenosis with a borderline aortic valve size not requiring surgery at this time.

Case IV

E.R.: A twenty-year-old asymptomatic male who had a known aortic systolic murmur since 1953; but who did not give a history of acute rheumatic fever. He was able to do heavy labor without difficulty. Physical examination revealed a B.P. of 110/85 and a regular pulse rate of 70. The heart was not enlarged. A harsh, Grade II, systolic murmur was heard at the base and was well transmitted into the neck vessels. There was an associated systolic thrill. The electrocardiogram was normal. Roentgenograms of the chest were normal. Left-heart puncture revealed a systolic pressure gradient of 75 mm. Hg. across the aortic valve.

It was felt that this patient had moderate aortic stenosis and that surgery was not indicated at this time.

Case V

D.A.: A forty-eight-year-old female, who gave no history of acute rheumatic fever, had been asymptomatic until age forty when she first noted slowly progressive fatigue and dyspnea. Five years before admission a diagnosis of rheumatic heart disease was first made. Physical examination revealed a B.P. of 100/60 and a regular pulse rate of 84. The heart was enlarged to the left. P-2 was greater than A-2 and M-1 was accentuated. There was a harsh, Grade II, systolic, aortic murmur transmitted into the neck vessels and well heard in the axilla. A Grade II-III, mid-diastolic, apical rumble with presystolic accentuation and an opening snap were heard at the apex. The electrocardiogram was normal. Roentgenograms of the chest and chest fluoroscopy revealed right ventricular enlargement, left atrial enlargement and calcification of the mitral valve annulus. The left ventricle was not enlarged. Left-heart puncture revealed an aortic systolic gradient of 77 mm. Hg. and a mitral diastolic gradient of 11 mm. Hg. The pressure-pulse tracings did not show evidence of mitral regurgitation.

It was felt that this patient had significant aortic and mitral stenosis requiring combined operative correction.

Case VI

D.F.: This forty-three-year-old female had had acute rheumatic fever at age twenty but had done well until one year before admission. At that time she developed progressive symptoms of dyspnea on exertion, orthopnea, paroxysmal nocturnal dyspnea and intermittent ankle edema. Physical examination revealed a B.P. of 130/65 and a regular pulse rate of 80. The heart was not enlarged. A-2 was faint

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and M-1 was accentuated at the apex. There was a Grade IV, harsh, aortic systolic murmur which was transmitted into the neck vessels and toward the apex. A Grade II, diastolic, apical rumble was heard at the apex, while a Grade I, diastolic decrescendo murmur was heard along the left sternal border. The liver was palpable two fingerbreadths below the right costal margin and the neck veins were slightly distended. An electrocardiogram showed non-specific ST-segment depression, while roentgenograms of the chest and chest fluoroscopy revealed left atrial enlargement, right ventricular enlargement and questionable left ventricular enlargement. Left-heart puncture revealed an aortic systolic gradient of 44 mm. Hg., with a mitral diastolic gradient of 5 mm. Hg. (Figures 5a and 5b). The aortic valve cross-sectional area was 1.03 cm.² while the mitral valve cross-sectional area was 1.4 cm.²

It was felt that this patient had both mitral and aortic stenosis and should have combined operative correction of these two lesions.

Discussion

Our present technique evolved gradually. Patient I did not have right-heart catheterization to calculate cardiac output or suprasternal puncture of the left atrium or aorta, while patients II and III had retrograde aortic catheterization.

Two of the patients reported above had murmurs consistent with aortic stenosis but were not found

to have significant narrowing of their valves. The prognosis in these patients is good without further treatment at this time. Another patient with moderate aortic stenosis may require corrective surgery in the future.

The remaining three patients had combined valvular lesions. The need for concomitant corrective surgery of both valves can be more fully determined as a result of these studies. Two of the six patients presented illustrate that a loud murmur is not an infallible indication of seriously disordered valve function in physiologic terms.

These studies are indicated in all cases of aortic stenosis since aortic valvulotomy is more successful before the patient has seriously deteriorated and developed severe left ventricular failure. Past experience has shown that a cross-sectional area of less than 0.6 cm.² is associated with progressive deterioration and the patient's early demise. These studies should aid the early selection of those patients requiring valvulotomy.

This technique is not wholly satisfactory for evaluating mitral regurgitation. Left ventriculography is more helpful in evaluating this lesion. Radiopaque dye (Diodrast) is injected through the left ventricular needle and regurgitant opacification of the left atrium evaluated with rapid serial radiography.*

*Six/sec. (Schonander-Stockholm, Sweden)

SUMMARY

(1) The history and various techniques in the study and assessment of mitral and aortic valve disease have been presented.

(2) Six cases who had been studied at Rhode Island Hospital have been presented and discussed. Our experience to date suggests that these studies are valuable in the diagnosis of the severity of mitral and aortic stenosis, but are not adequate in evaluating mitral regurgitation. For the latter, ventriculography provides a more accurate means of objective assessment of the presence and degree of mitral valvular insufficiency.

(3) These techniques may rule out significant aortic valvular pathology, though the patient may have a loud, harsh aortic systolic murmur.

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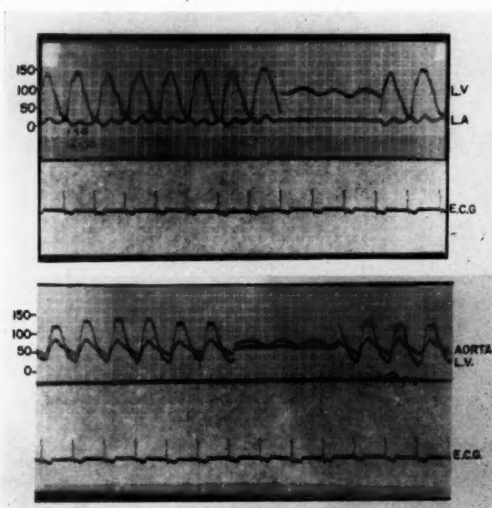


FIGURE V (a)

D. F., a 43-year-old female. Superimposed LA and LV tracings. Mitral diastolic gradient of 5 mm. Hg.

FIGURE V (b)

Superimposed LV and aortic tracings. Aortic systolic gradient of 44 mm. Hg.

THE HOSPITAL AT PORTSMOUTH GROVE*

SEEBERT J. GOLDOWSKY, M.D.

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MANY VETERANS of World War II knew Lovell General Hospital as a vast, efficient installation, located at Fort Devens, Massachusetts. Few would be aware that there had been an earlier hospital of the same name in Rhode Island during the Civil War. The first Lovell General Hospital, established at Portsmouth Grove on Aquidneck Island in the second year of the conflict, was, during its brief career, an important part of the local scene.

On July 6, 1862, a pleasant and peaceful Sunday morning, there arrived suddenly and unexpectedly in Newport Harbor the first of two transports loaded with casualties from the battle areas to the south. With their arrival the actuality of war came to the placid and complacent countryside with explosive force, prompting a reporter at the scene to comment: "The stern realities of war are now brought to our own doors." The excitement and confusion which followed were epic.

The steamer *America* arrived at 8:00 A.M., the steamer *Atlantic* following later at about 5:00 P.M., bringing in all some 1,724 sick and wounded. These were casualties from the Army of the Potomac, evacuated from the hospital at Yorktown, Virginia. The decision to bring them north had been improvised under the pressure of military necessity. Virtually no preparations had been made for their arrival.

Proceeding to Portsmouth Grove, several miles up the bay, the vessels reached their destination an hour or so after entering the harbor. Notice of the arrival of the first ship having been quickly disseminated through the town of Newport, every conceivable conveyance started for Portsmouth Grove. Carriages, wagons, omnibuses, and sailboats set out jam-packed with citizens laden with cakes, pies, jellies, milk, lint and clothing. Others who had no means of transport traveled on foot. There were an estimated eighteen hundred citizens, including a group of physicians, on the road that day, "more in

fact," as one observer remarked, "than had been since the British and Hessian troops occupied the Island during the Revolutionary war." It was, incidentally, one of the hottest days of the year.

The horde, descending upon Portsmouth Grove, offered to help unload patients and supplies, but their services were peremptorily refused. The steamer *America*, which had arrived first, was under the command of the executive officer, Dr. G. C. Striebling, while the commanding officer, Dr. Francis L. Wheaton, was still at sea on the steamer *Atlantic*. Striebling is reported to have told the teeming throng that their services "were not needed"; at any rate he would not allow the sick to be moved. This was interpreted as callous indifference to the suffering of the brave lads.

The plain fact is that he probably lacked the authority to act in the absence of his commanding officer; but the emotional mob were in no mood to make allowance for orderly military procedure or the protocol of rank. Angry and frustrated, most of them returned to Newport.

Upon the arrival late in the afternoon of the steamer *Atlantic*, the bay steamer *Perry* sailed for the Grove from Newport with four hundred determined people on board. Surgeon Francis L. Wheaton was now in command. "After some sharp talk between the surgeon and our citizens," according to a contemporary news story, "they were allowed to assist in carrying tents, &c., to the shore." The landing of the casualties, however, did not commence until Monday morning. Progress was slow, as might be expected, but by Thursday all were on shore and had been placed in reasonably comfortable quarters. This in brief is the story of the origin of the hospital at Portsmouth Grove.

These incidents were followed by a sharp controversy in the press in which the conduct of those concerned was criticized severely and bitterly. The episode can be more objectively appraised, if we explore briefly its historical background.

The ill-fated Peninsular Campaign, which provided the cast for this drama, had gotten under way early in April of 1862. General George B. McClellan argued that an operation on the Peninsula lying between the York and the James Rivers in Virginia offered the shortest route to Richmond. The roads on the Peninsula, he reasoned, were passable at all

*Read before a joint meeting of the Providence Medical Historical Society and the Benjamin Waterhouse Medical History Society at Boston, Massachusetts, on March 16, 1959.

continued on next page

seasons and there were few natural obstacles in his path. Gunboats on the rivers could protect his flanks, while in the unlikely event of defeat, he could fall back on Fortress Monroe at the mouth of the James River, his southern and left flank. He was fatally wrong in all respects except the last. The Peninsula, fifteen to seventeen miles wide, is marshy and thickly wooded, and is cut by many small streams. Their estuaries are flooded by the tides, while their upper reaches broaden into swamps which, in the spring rains, become a miasmatic morass. Richmond was seventy miles from tidewater.

McClellan began landing his forces at Fortress Monroe on April 1. One month later, on May 5, Yorktown, at the mouth of the York River, his northern flank, fell without a battle and after a fruitless siege. He set up his communications zone bases at Yorktown and Fortress Monroe. These establishments included hospital facilities.

His subsequent advance up the Peninsula carried him to within six miles of Richmond. On the way he established advanced bases at Harrison's Landing on the James, and at White House Landing on the Pamunkey River, a tributary of the York, the latter becoming his personal headquarters. As he continued his forward progress his forces became split by the treacherous Chickahominy River, a tributary of the James, into northern and southern sectors. The Chickahominy was an erratic and sluggish stream spreading out into swamps and flowing around many islands, forming a valley from a half mile to a mile in width. In dry weather it is hardly more than a brook, but only moderate showers could convert it into a formidable obstacle. To keep communications open between his right and left flanks, McClellan devoted precious time to the building of bridges across this stream.

On the night of May 30, the rains, which had already been sufficiently heavy to convert the reputed "all-weather" roads to boggy and sticky messes, came with a vengeance. It was one of the worst storms in the memory of man, and all but one of the bridges went out. Although for a time McClellan was able to keep up his pressure on Richmond, his position became increasingly untenable. During the early weeks of June he had already given thought to the desirability of transferring his base from White House Landing on the York to Harrison's Landing on the James, thus consolidating his forces south of the treacherous Chickahominy. He had initiated preliminary planning with that objective as early as June 18. President Lincoln, who was, of course, never happy about the Peninsular venture, had expressed misgivings about the deployment of McClellan's troops. Suddenly on June 26, Lee, who had but recently been designated commander-in-chief of Confederate

forces, struck a sledgehammer blow at McClellan's right north of the Chickahominy, aimed at his base at White House Landing. It was that night that McClellan gave orders to withdraw to his new base at Harrison's Landing to the south.

... Seven Days' Battle

The rest of the week was devoted to a desperate holding action known as the Seven Days' battle, while a difficult, massive and complicated retreat was carried out in the mud. The redeployment, and in fact the battle itself, came to an end on July 1. The retreat was in many respects a memorable military undertaking, but for all practical purposes it put an end to the Peninsular Campaign.

With the whole countryside a quagmire, combat conditions were beyond belief. In the sweltering heat of June the malarious swamps and the polluted waters of the sluggish streams became veritable fountains of disease. Malaria and typhoid stalked the ranks. The death rate was appalling, and the hospitals were under extreme pressure. Jonathan Letterman,* who at this very juncture came upon the stage, has recorded these vivid observations of the scene: "In obedience to orders from the War Department, dated June 23, 1862 I reported on the 1st day of July to Major-General McClellan at Haxhall's Landing, on the James River, for duty as Medical Director of the Army of the Potomac, and on the 4th took charge of the Medical Department of that army.

"On arriving at the White House, June 28th, I found there was no communication between that depot and the headquarters of the army, then en route for James River. . . . It was necessary that the medical supplies and the transports for the wounded and sick should be sent up the James River to meet the wants of the Army." Unable to obtain the requisite orders from Surgeon Tripler, whom he was to succeed as medical director, the telegraph wires having already been cut, he ordered the medical director of transportation to proceed up that river with the available supplies and vessels with all possible dispatch. "They reached Harrison's landing in time to be of the greatest service. The troops for several consecutive days and nights had been marching and fighting among the swamps and streams which, abounding in this part of Virginia, render it almost a Serbonian bog.** The malaria arising from these hotbeds of disease began to manifest its baneful effects upon the health of the men when they reached Harrison's Landing. The labors of the troops had been excessive, the excite-

*Creator of the famed "Letterman Plan" for the evacuation of sick and wounded upon which the modern system of medical evacuation has been based.

**The Serbonian bog was a marsh near Lake Serbonis in ancient Egypt famous for engulfing travelers. Lake Serbonis is now a dry lake.

ment intense; they were obliged to subsist upon marching rations, and little time was afforded to prepare the meagre allowance. They seldom slept, and even when the opportunity offered, it was to lie in the mud with the expectation of being called to arms at any moment. . . ." Due to their prolonged subsistence on inadequate rations scurvy was rampant.

While these grandiose events were taking place, less dramatic moves were being made which have a more direct bearing on our story. On June 8, two interesting communications went forward from the office of William A. Hammond, surgeon general of the United States Army. The first was a letter directed to Surgeon C. S. Tripler, then Medical Director of the Second Army of the Potomac:

Surg: Genls Office
June 8, 1862

Sir:

As it is manifestly apparent that the General Hospital at Yorktown is most disadvantageously situated in almost every respect, it is deemed necessary for the well being of the sick that this Hospital should be removed.

You will therefore at the earliest practicable moment direct the Medical Officer in charge to abandon the buildings at that place and remove the tents with his whole staff to the vicinity of Fortress Monroe, and with this view you will direct him to select a site and make requisition on the Quarter Master's Department for shed Hospitals in addition to the tents. The plans for these sheds will be furnished from this Office.

I am Sir, Very respectfully,
Yr: ob: St.

W. A. Hammond
Surg: Genl. U.S.A.

The second went to General M. C. Meigs, quartermaster general of Federal Forces:

Surg: Genl. Office
June 8, 1862

General:

I have the honor to inform you that I have instructed Surgeon Tripler to break up the General Hospital at Yorktown and to remove the whole establishment to the vicinity of Fortress Monroe. I have to request that you will direct sheds to be erected at the point to be selected, capable of accommodating about 1000 men. With the tents now on hand there, 2000 men can be accommodated. I have also directed Surgeon Cuyler to abandon the Hygeia Hospital which I understand is rented at 1000 dollars per month, and to move this establishment to tents and sheds. I have therefore to request that the necessary sheds for 1000 men may be as soon as possible erected. I will furnish you with plans for these sheds immediately.

By the adoption of the plan above specified, the transportation of the sick north will be in a great measure avoided, the health of the sick and wounded improved, and the abatement of the great nuisances — the Hygeia Hospital and the General Hospital at Yorktown — secured.

I am Sir, Very respectfully &c

W. A. Hammond

Surg: Genl. U.S.A.

These orders are interesting in several respects. In the first place they antedated by some eighteen days the final retreat orders issued on June 26. Furthermore the observation that the hospital at Yorktown "*is most disadvantageously situated in almost every respect*" was peculiarly prophetic. It is not unreasonable to conclude that the contemplated move of the hospital from the York to the James was motivated to some extent at least by the strategic considerations previously discussed, even though no official records are available which confirm this view.

The Hygeia Hospital at Fortress Monroe was located in a requisitioned hotel of the same name. The hotel's name seems to have been somewhat prescient, although at the time of these events its appropriateness would seem to be somewhat doubtful in view of its being characterized as a "great nuisance."

The transfer of the medical installations ordered on June 8 "at the earliest practicable moment" seems to have met considerable delay, probably inevitable in view of the existing military and logistical situation. At any rate at the close of the Seven Days' battle on July 1 the casualties quartered at Yorktown had not yet been moved. After the recapture of White House Landing by the Confederates and the retreat of Union forces south of the Chickahominy, Yorktown would inevitably and promptly be over-run. There were in its hospital in excess of seventeen hundred sick and wounded in various stages of convalescence. None of these had participated in the most recent battles.

Dr. Wheaton, Medical Officer

The medical director at Yorktown was Dr. Francis L. Wheaton of Providence, Rhode Island, son of the eminent Dr. Levi Wheaton and a graduate of the Medical School at Brown University in the class of 1826. He had served as a surgeon in the Mexican War in 1847 and had completed four terms as surgeon general of Rhode Island. At the outbreak of the War of the Rebellion, he had been one of the first to respond. Both his military and his medical background were impressive.

Dr. Wheaton received orders to evacuate the hospital at Yorktown forthwith. The scenes which followed are well described in excerpts from an official report:

continued on next page

"In accordance with military orders received by the Medical Director in charge at Yorktown, we were advised, that the entire Hospital was to be immediately removed to two Steamers, lying in the York river, the 'America' and the 'Atlantic,' and on the morning of the third of July, we were requested to be at our respective places of duty at an early hour, and assist in the removal of the sick and wounded, hospital stores, baggage &c. The Medical Director, remaining upon the wharf the entire day, gave his personal attention to the loading of the 'America' which was completed at seven o'clock in the evening, and he then took his position on board of the 'Atlantic' lying in the stream, and unable to approach the wharf, and personally directed the disposal of the men, as they were conveyed to the steamer in a transport.

All were safely on board of the 'Atlantic' on the morning of the fourth: the stores however, were not all received on board until late in the afternoon, and our departure was delayed until daylight on the morning of the Fifth.

It was expected, that the 'America' would sail in company with us, but she left on the afternoon of the fourth of July, with positive orders, as we were afterwards informed, to await our arrival at Newport and to have no communication with the shore.

The orders were disobeyed, and on our safe arrival at Portsmouth Grove, R. I. on the evening of the sixth of July, she was lying at anchor there."

A newspaper report stated that Wheaton had received orders to proceed to Fortress Monroe from Yorktown, but upon arriving there found no accommodations and assumed the responsibility of proceeding to Newport. A later account stated, probably more accurately, that he had been ordered at Monroe to move on. It has not been possible from official sources to determine which if either of these accounts is correct as no written orders have been found. It is reasonable to assume, however, that the situation at Fortress Monroe was one of extreme activity and possibly of utter confusion, with the whole of the Peninsular armies retreating there in force. The casualties of the Seven Days' battle totaled over 15,000, of whom over 8,000 were wounded. About 2,500 sick and wounded and many hospital stores were abandoned to the enemy at Savage Station. The remaining 6,500 casualties eventually found their way to Harrison's Landing and Fortress Monroe. The precipitate nature of the retreat is indicated by the fact that, among the booty, 31,000 small arms alone were captured. Dr. Wheaton and his convalescents were probably not a welcome sight at Fortress Monroe.

Some weeks earlier at the request of Governor

Sprague inspection of various sites on Narragansett Bay had been made with a view to establishing an army general hospital in this state. The location, accessibility and reasonableness of terms had recommended Portsmouth Grove, a small summer resort, as the most eligible location. The recommendation was received favorably by the Federal government and according to town records in Portsmouth, a lease was signed with the owners effective June 1, 1862 by William W. McKim, assistant quartermaster of the United States Army. The lease was renewable annually at the pleasure of the government. Dr. Wheaton was undoubtedly aware of these facts, and the foresight of the local authorities provided for him and his charges a welcome and convenient refuge in the emergency.

Portsmouth Grove Selected

Messages were telegraphed ahead to Mayor Cranston of Newport that the transports were on their way to Rhode Island and he was requested to station pilots in the harbor for the purpose of directing them to Portsmouth Grove. Much of the early confusion upon arrival was created by an unidentified surgeon landing at Newport and requesting aid. The official report indicates, as previously noted, that this action was unauthorized, and that the seeming intransigence of Executive Officer Striebling was probably in accordance with his orders. Upon the arrival of Dr. Wheaton, unloading of the transports began in earnest. Until their arrival, the troops had been under the impression that the armies in the field had been totally annihilated, having received no word of the battle since sailing from the Peninsula. When they learned that the enemy had indeed been held successfully, they let up a great cheer. This intelligence boosted their morale even more than the fresh air.

According to the official report, the "voyage was an exceedingly pleasant one, few suffering from sea-sickness, and all being cared for, as well as the military necessity of our hasty removal would allow." The newspaper reports confirmed that the passage had been quick and easy, and that the weather was fine and the sea smooth. In other respects, however, the trip was extremely uncomfortable. Over 1,700 men, many seriously ill, were crowded into two vessels, which to our modern eyes, would undoubtedly seem small, although at the time they were described as "immense." The air between decks and in the holds was hot and stifling and the more severely ill suffered extremely. Two died en route and were buried at sea. But Dr. Wheaton had done what he could to make the men comfortable. There were nine surgeons on board and one hundred eight nurses detailed from the several regiments. The hospital stewards and nurses, all male, were distributed about the ships with definite assignments, and attention was given, as far as fea-

ible, to the cleanliness of the men and the sanitary condition of the ships. Despite these efforts, many were ragged and dirty, even lousy. With patients suffering from malaria, typhoid, diarrhea and infected wounds, the stench in the close quarters was terrible.

Dr. Wheaton, late Sunday afternoon, ordered the unloading of some tents and other equipment; but the debarkation of patients did not begin until Monday morning. The first day about forty of the sickest were brought ashore, including two or three wounded, and these seemed to be much relieved by exposure to the fresh air. The unloading was of necessity a slow and laborious procedure, although the citizens exhibited much impatience over the delays. Many of the sick could walk, some on crutches, but many others had to be brought ashore on litters. The shallow waters required the steamers to remain at anchor and the discharge of cargo was accomplished with the aid of steam tugs and lighters. By Thursday morning all were on shore and placed in comfortable quarters. Soon after arrival the medical officers had, according to the quaint custom of the military, appropriated the small hotel building on the grounds for their own quarters, causing bitter criticism among the bystanders.

The tents were pitched on the lawn south of the hotel and were cooled by the prevailing southwest winds. They were mostly large hospital tents, placed in pairs, so that each unit accommodated sixteen to twenty patients. The cots were of iron with wooden slats and straw mattresses. In the confusion men were often landed before there were beds available, and tents were landed without poles. As a result of the disorganization some of the men were left lying on litters, some on the ground exposed to the burning July sun. Gradually, however, the situation improved.

By the end of the first week some twenty more of the patients had died, several while still on board ship in the harbor. A cemetery was set up on the grounds for their interment and the graves were suitably marked. There is some indication that the well-meaning throngs milling about the grounds were responsible for a few deaths due to the injudicious plying of seriously ill patients with food, drink, and other delicacies. According to one eyewitness account "one poor fellow, quite sick but apparently recovering from a severe attack of typhoid fever, was laughing and chatting with his comrades, when he was suddenly convulsed and in a few minutes was dead. The physician and nurse were both surprised, and could account for it only on the supposition that he had eaten too much of some dainty, furnished with the best of intentions. A number of such sudden deaths have taken place. . . ."

In order to establish discipline about the area,

the Newport artillery, a local militia outfit, was assigned to guard duty, and a detail of sailors from the frigate *Constitution* helped in the erection of tents and in other ways. Surgeon Wheaton in due course instituted a system of passes, and visitors were no longer allowed to distribute gifts, everything now being given out by the Sanitary Commission, an organization somewhat analogous to the Red Cross. Clothing, linens and bedding in large quantities were donated by the people of Newport, but these were now utilized systematically in accordance with the needs of the hospital and patients.

Among the patients were some sixty or seventy Confederate prisoners. Complaints were numerous and loud to the effect that they had received favored treatment at the expense of "our boys." Visitors reported that they found prisoners wearing articles of clothing intended for Union sufferers and that said prisoners reacted with insolence and sometimes with utter vulgarity when this was called to their attention. Such conduct was most shocking to Victorian ears; but on the whole, the prisoners were a soft-spoken and gentlemanly lot. Their southern charm seems not to have been wasted, as "some well-dressed ladies conspicuously lavished their attentions upon the foes whose wounds had not in the least mitigated their enmity to the Government, or their determination to fight against loyal men." The same writer, however, was constrained to observe more objectively: "Some of the stories of these exclusive attentions to rebels were doubtless exaggerated."

While these stirring events were taking place, all was not austerity on Aquidneck Island. The *Newport Mercury* noted on July 19 that "the season [at Newport] has now fairly opened and a large number of visitors are enjoying our salubrious climate. The Hotels, with the exception of the Atlantic and Bellevue, which are closed, are doing a

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Lovell General Hospital, U.S.A., Portsmouth Grove, Rhode Island. View from Dyer's Island. Drawn from Nature & Lithographed by J. P. Newell, 1864. Printed by Endicott & Co., New York. Courtesy of Miss Alice Brayton.

good business and present the appearance that they have usually during the month of August. The number of cottages rented is one hundred and nine. . . ."

By the end of the month the hospital was functioning much more smoothly, and on the 30th Dr. Wheaton sent forward the following communication to Surgeon General Hammond:

U. S. Hospital
Portsmouth Grove, R. I.
July 30, 1862

Surgeon General
W. A. Hammond
U. S. Army

Sir

I have the honor to report that on my arrival from Washington to this Post, I found so many things requiring my personal attention, that I requested the Medical Gentlemen serving with me, to furnish a report of our voyage from Yorktown with the sick to this place, and all circumstances connected with our embarking at Yorktown and our debarkation after our arrival here, trusting their report, which you will please find inclosed, will meet your approbation.

I have the honor further to state, that I have this moment received an order from your office relieving me from duty at this Hospital, and to join my Regiment. Am I to await your orders to instruct me to whom I am to transfer the Government property now in my hands?

Very Respectfully,
Your Obt. Servt.
F. L. Wheaton

Dr. Wheaton was doubtless an ambiguous, controversial and unhappy figure. His devotion to duty and to his men is beyond question. Yet there is evidence that, even thirty-five years later, the acrimony surrounding him had not completely subsided. It would take an officer of superhuman qualities to carry out an operation of this magnitude without confusion. The unfamiliarity of the populace with the realities of modern warfare, and the lack of preparation for his arrival were important factors in the situation. There is reason to suspect, however, that his public relations were faulty, the local citizens failing consequently to comprehend either the enormity of his problem or the necessity for following sound military procedure.

Despite acid comments in newspapers and emotional letters to the editor, his conduct of affairs was defended vigorously by more experienced and cooler heads, including not only his professional and military colleagues, but the patients in the hospital as well. After a careful review of the affair, Bishop T. M. Clark stated: "I have made this statement of facts from the simple desire to do justice

where I am satisfied injustice has been done. . . ." Because of complaints which had reached New York, Dr. J. Oakley Vanderpool, surgeon general of the State of New York, was sent down by the governor of New York to look over the installation. In a letter to Dr. Wheaton, which was simultaneously released to the press, he stated: "Permit me to make a more formal expression, than the one made to you personally, upon the condition of the hospital. . . . Though but four days had elapsed since your arrival at the spot [letter dated July 11] with eighteen hundred sick and wounded, where not the slightest preparations had been made. . . . I found five streets of tents, every man comfortable in bed, all well fed, the regular duty of each medical officer and nurse assigned, and a degree of personal cleanliness creditable to the short period which had elapsed. . . . We should record and encourage the charitable and benevolent spirit of our people. At the first thrill of suffering, they press as one eagerly to aid by gifts and works in the amelioration of our able soldiers. Placed as you are, chief of so large a hospital, it is very trying, and at times difficult to control and not yet chill this charitable spirit. I am satisfied herein lies your chief cause of anxiety." He concluded: "I make this expression in no spirit of fulsome compliment . . . , but as simple justice to one occupying a most difficult and arduous position. . . ."

The official report prepared by his medical officers stated: "We feel it to be our duty to bear our united testimony to the fitness of Surgeon Wheaton for the direction of a Hospital of this magnitude. . . . With respect to the charges, which have been so maliciously and unjustly circulated, we desire to state that, to our positive knowledge, they are without foundation."

Dr. Wheaton, upon being relieved of duty at the hospital, returned to his regiment, the Second Rhode Island Volunteers, spending the remaining three years of the war in the general vicinity of Washington. He was mustered out of service at the close of the War, having attained the rank of Brigade Surgeon. He died in 1895 in his ninety-second year.

Permanent Installation Built

His replacement, Dr. D. J. McKibben of Philadelphia, whose stay was to be brief, arrived sometime during the ensuing two weeks. During this period the plans for a more permanent installation were initiated. These called for a total of fifty-eight structures including twenty-eight ward buildings. The wards were to be of one story, 160 feet long and 30 feet wide. Other structures eventually to be erected included mess hall, kitchen, bakery, laundry, drying rooms, several buildings for hospital quartermaster stores, dispensary, commissary department, officers' quarters, quarters for female

nurses, chapel, blacksmith and carpenter shops, stables, barracks for hospital guards, knapsack depository and morgue. In addition there were a post office, express office, "Cole's store" (a sort of post exchange), a bathhouse containing facilities for medicated baths, and even special diet kitchens. A steam plant provided hot running water to all areas and steam for the laundry and for cooking. The carpenter shop had a steam-driven circular saw, and there was a steam pump to provide water for extinguishing fires.

The grounds comprised about twelve acres running along the bay. Situated on a rise at about its mid-point was the former summer hotel which served as the administration building. On either side was a series of fourteen pavilions, each constituting a division of the hospital. A main avenue ran north and south from the central building with the individual wards placed obliquely on either side of it like feathers on an arrow. The wards were joined by a covered corridor, facilitating communication in the winter. All pavilions contained partitioned areas for bathroom, lavatory, and toilet at one end, and for wardmaster and nurse at the other. Each ward could accommodate fifty-six patients. Thus the hospital had a rated capacity of about 1,500 beds, but it could be expanded at will to 2,000 or more by the erection of tents. The budget ran to about fourteen hundred dollars a day, Civil War dollars.

Running water was provided by an interesting device. Springs at the top of the hill, seventy feet above the hospital, were dammed, forming a reservoir; the water was led in through iron pipe furnished by the Hope Iron Foundry.

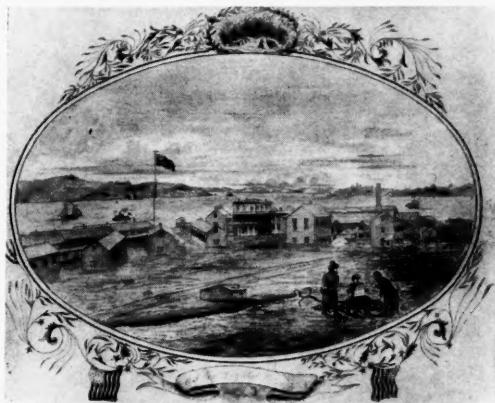
Portsmouth Grove, located in the Town of Portsmouth, eight miles north of Newport, was on a pleasant bluff overlooking Narragansett Bay, an area now incorporated in the Melville Naval Reservation. The following contemporary description of the site as approached from the land gives some idea of its beauty: "Just back of us is a splendid group of majestic old elms, and below us a twinkling brook bordered with elder bushes in full bloom, with occasional wild roses peeping out from the grass. On our left, north and west of us, we see the two steamers landing sick and wounded cargo. Down the steep hill, through the valley, over a little bridge thrown across the brook and we soon arrive at a turning marked 'To the Portsmouth Grove House.' We turn obediently and keep turning to an apparently endless road, until at last we come in full view of the bay. . . ."

Along the shore adjacent to the hospital ran the tracks of the Old Colony and Newport Railroad. Quaint little trains drawn by puffing locomotives plied back and forth between Fall River and Newport. A wharf capable of discharging vessels of eight hundred tons had existed prior to the estab-

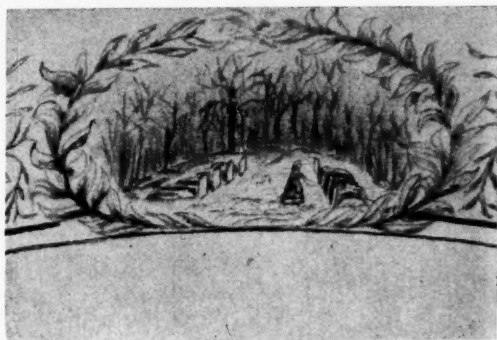
lishment of the hospital. This was found to be inadequate to berth the large military transports used to carry patients, but despite frequent recommendations that it be extended, the project was never carried out.

Dr. McKibben remained in charge for the balance of the summer. He was well liked and did a satisfying job of organizing the sizable institution. On August 17, the steamer *United States* sailed with 662 soldiers fit for duty. Previous discharges brought the number remaining to 800, but new and frequent arrivals from the front were to keep the hospital very active indeed. During the first week in September 1862, 1,204 fresh casualties were brought in and it was announced shortly thereafter that the census had reached 2,400, possibly an all-time high. At no time, however, was a hospital registration in excess of 1,000 unusual. During the first full year of operation (to August 1, 1863), 6,866 patients were received, 414 of these being Rhode Island men. There were in the same period 124 deaths, of which 101 were buried in the hospital cemetery.

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U.S. General Hospital, Portsmouth, Rhode Island. Pen and ink sketch by J. Baker and J. M. Tabor, Jr. Courtesy of Newport Historical Society.



Detail from sketch (Figure II) by J. Baker and J. M. Tabor showing cemetery at Portsmouth Grove.

Surgeon Edwards Takes Command

Early in September of 1862 Surgeon Lewis A. Edwards, a regular army officer holding the rank of major, was ordered to permanent command at the Grove, relieving Dr. McKibben. He came well recommended and proved to be a popular and efficient administrator. He was a fine-looking man, well-proportioned and over six feet tall. He had a stern, but pleasant manner, and commanded the respect of his men. His staff, which varied in number as personnel moved in and out, comprised on the average four assistant surgeons and nine acting assistant surgeons, the latter being civilian physicians under contract holding simulated rank. There were also a hospital steward, a chaplain and a quartermaster officer. The hospital guards were separately organized.

Shortly after Surgeon Edward's arrival, Miss Kate P. Wormely was appointed chief hospital nurse. She set to work immediately engaging her staff. The duties of female nurses were largely of a housekeeping nature. Miss Wormely had spent the early months of the War with the Sanitary Commission near Washington. In later years she gained eminence as a French scholar, based on her English translations of Balzac and Molière. One of her assistants, who was to become well-known locally, was Agnes Wilbour (Richardson) of Newport, who with her mother, Mrs. Mary Simmons Wilbour, were among the first to volunteer. Mrs. Richardson, who died in 1933 in her ninety-fourth year, had been in charge of hospital linens. She was reputed, at the time of her death, to be the last surviving Civil War nurse.

The Newport Artillery, which had served as hospital guard almost from the beginning, was relieved on September 29, and a letter of thanks was dispatched to its commanding officer. It was replaced by a chartered infantry company from Providence. The *Newport Mercury* reported: "Guard duty at Portsmouth Grove is not so pleasant as many suppose. . . . The Providence Infantry were compelled to draft the men, and of the sixty unfortunates, thirty-two procured substitutes by paying a premium. The pay is six dollars and fifty cents for fourteen days' duty, day and night. . . ." It should be noted, however, that some of those assigned were combat veterans who had been wounded in action. A permanent hospital guard was organized in the latter part of November and mustered into service on December 6.

One November 11, Miss Wormely sent an open letter to the *Newport Mercury* requesting foods and delicacies of all varieties and in large quantity to provide a Thanksgiving repast for her charges as attractive and sumptuous as the generosity of the good citizens could provide. The holiday was highly successful and the newspaper reported on Novem-

ber 29 that "after the men were fully satisfied with meats, the pies and cakes were served out, and a happier set of beings it would be difficult to find. . . ." The Naval Band was present and provided suitable *divertissement*.

The Chapel, which had been financed by the several churches of the state through popular subscription was dedicated on Christmas Day. The two-story building, with a library and reading room on the first floor, was to cost about \$1,400. At the time of its dedication about 800 books had been donated to the library, the number eventually growing to 1,600. The Chapel walls were decorated with shields inscribed with passages from the *Scriptures*, and it was equipped with a handsome melodeon. The auditorium could seat five hundred.

Toward the end of January 1863, the transport steamer *St. Marks* arrived with two cases of small-pox among its passengers. All of the patients from this ship were placed in a separate isolation ward. This move proved fortunate as some thirteen more cases appeared among those exposed. All of the other patients in the hospital were vaccinated, and Dr. Edwards requested that all persons refrain from visiting the hospital. No one was permitted to leave the grounds, and the Newport City Council passed and advertised an ordinance setting up a two-way quarantine between the city and the hospital. These measures were quite successful as it was noted on May 2 that "there are no malignant fevers at present, and the small-pox has disappeared."

Affairs in general were kept firmly in hand as indicated by the following brief vignette: "Our informant says he never saw so many at any previous time on crutches as there are at present. The men are perfectly contented with their treatment . . . and only long for their friends at home. Every department is kept in the most thorough state of cleanliness, and has the personal supervision of Dr. Edwards and Miss Wormeley, both of whom have the good will of the brave boys." The military touch was everywhere obvious as "the most perfect neatness is observed in beds, bedding, and in fact the whole establishment, from floor to ceiling." Nothing was too trivial to report in the papers and on one occasion the menu for a whole week was published. The food was obviously plain, but substantial and plentiful in typical army style.

Hospital Named Lovell General

In a newspaper article dated May 16, 1863, the name Lovell was applied to the hospital for the first time. Its official name became "Lovell Hospital, Portsmouth Grove, R. I." It was also designated variously as Lovell U.S.A. Hospital; Lovell General Hospital, U.S.A., and U.S. General Hospital, Portsmouth Grove, R. I. It was named after Joseph

Lovell, surgeon general of the United States Army from 1818 to 1836, and first great organizer of the medical department.

The summer of 1863 found the country deeply involved in the war. Riots were occurring in New York City over the draft, although it had been accepted calmly in Rhode Island. Casualties continued to roll into the hospital. Yet these serious matters put no damper on the festivities at Newport: "The season is fast getting to its height and everything indicates one of prosperity. The number of visitors in the city is equal to that of last year which was considered the most successful of any previous one. Between six and seven thousand non-residents are passing the dog-days in our salubrious climate. . . . The Beach presents a lively appearance each morning as the hundreds of bathers in their varied costumes are gamboling in the surf. . . . We counted over three hundred vehicles on the Avenue Thursday afternoon, representing the wealth and aristocracy of all the larger cities in the loyal States. . . ." There were at that time some 235 general hospitals, caring for about 48,000 patients.

The inmates of the hospital kept themselves busy in various ways. Convalescents helped out in the kitchens, mess halls, laundry, carpentry shops and as teamsters. They spent their spare time playing checkers and cards, although, in accordance with hoary Army regulations, not for money. Patients were not permitted to receive liquor from visitors.* Nearly all chewed tobacco, and spittoons were a necessary fixture in all wards. On one occasion a wardmaster gained the recognition of the Commanding Officer by requisitioning extra spittoons for his ward.

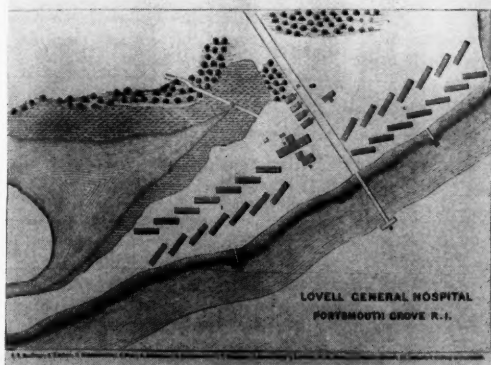
The patients seemed to derive pleasure from arranging little ceremonies. On one occasion a silver tea set was presented by them to one of the Acting Assistant Surgeons in appreciation of his services, and on the same occasion a silver pitcher and goblets to a wardmaster, and a gold watch to Nurse Agnes Wilbour, linen room mistress. At another time there was a formal flag raising accompanied by cheers and a thirteen gun salute. The flag, donated by the citizens of Newport, was unique in that it had the Rhode Island coat-of-arms on one side and a cock on the other, "the bird which was by the ancients sacrificed to Aesculapius, the God of Medicine [and it was inscribed], with the motto, 'dum spiro, spero (while I live, I hope).'"

*There is a well-grounded tradition among the oldest inhabitants of Portsmouth, passed on to them by individuals then alive, that liquor (bootleg, no doubt) found its way into the inner sanctum in the following manner. An empty jug, along with money, was placed in the hollow trunk of a certain tree on the grounds. From time to time a local merchant, with whom prior arrangements had been made, replaced the empty jug with a full one.

Mr. Benjamin J. Tilley, proprietor of a newspaper store in Newport, deserves special mention in connection with the entertainment of the patients. He seems to have been a goodhearted and generous soul, and became a familiar figure about the hospital as he hobbled along on his crutches bringing words of good cheer and little gifts for the men. He kept the patients supplied with newspapers and periodicals and made his emporium the depot for various collections. On one occasion the following note appeared: "Mr. Benjamin Tilley acknowledges the receipt of many articles of clothing much needed for the comforts of the poor fellows. . . ." In November, 1864, he arranged for a Thanksgiving dinner for the soldiers and later for a liberal and successful one on Christmas. Probably his most ambitious undertaking was the Fourth of July celebration in 1865. "We who have been," said a newspaper notice, "kept comfortable by our brave soldiers for the last four years ought not to forget those at Lovell Hospital on the 4th of July. B. J. Tilley has it in hand. Help it by subscription, be it large or small." The eleven hundred men still on hand were entertained with an oration, appropriate ceremonies, fireworks in the evening, and, we presume, food.

At intervals, particularly during the holiday season, furloughs were granted to those well enough to travel. As is true in all wars, the enlisted men were chronically short of cash. This condition was aggravated by the tardiness of the paymaster in making his rounds, the arrears reaching at times the unreasonable sum of eight or ten months' pay. Money was solicited to help the men on their way, or on occasion they were carried free of charge on public conveyances through the kindness of transportation officials. Sometimes they were obliged to hire private vehicles and under such circumstances profiteering was not unknown. After one such experience the press reprimanded an unnamed individual for taking advantage of poor fellows "desir-

continued on next page



Map of Lovell General Hospital in the official Medical and Surgical History of the War of the Rebellion.

ous of visiting their homes after two years absence in fighting our battles."

Medical care at the hospital was probably of good quality relative to then current standards. There is no mention of operating facilities or of operations, but most of the surgery, which consisted of amputations and of removal of missiles, was performed in the forward areas. In a special report to Governor Sprague submitted in December, 1862, Dr. Lloyd Morton of Pawtucket had doubted the wisdom of establishing regional hospitals. Although his judgment was probably open to question, he made the following interesting observation: "This transfer [to installations near their homes] works to the peculiar disadvantage of one class of patients, *viz*: those who have suffered amputation of the leg or thigh. At St. Elizabeth's Hospital [in Washington], the Government has established the inventor of one of the most perfect artificial limbs, who is constantly employed (at the expense of the United States) in fitting limbs. . . . Why, then should this class of patients be deprived of this benefit by being removed, and in all probability discharged from the service, in some hospital remote from Washington?" Yet, prosthetic facilities were available at at least one other center, the hospital at Central Park, New York, two amputees of record having been referred there from Lovell Hospital. It is indeed noteworthy that medical authorities had conceived the idea of a special center eighty years before the beginning of World War II.

The monumental, but unfortunately little read, *Medical and Surgical History of the War of the Rebellion*, contains protocols of four cases that were treated at Lovell Hospital. The first was a gun shot (Minié ball) wound of the right thigh, penis and scrotum. The second was of a soldier admitted for treatment of an upper arm stump, following amputation in the field for a gun shot found near the shoulder. This patient was eventually transferred to Central Park for an artificial limb. The third report was of a patient who had suffered a wound of the ankle, resulting in a leg amputation. Delayed healing in both of the above cases was the chief problem, and "stimulating applications, including bromine" were utilized.* The nature of the bromine preparation is not stated. The latter patient also was sent to Central Park for disposition.

The only mortality among the four reported cases was, oddly, not a battle casualty at all, but a hospital guard who had been in trouble because of an infraction of discipline:

*According to Dr. J. Collins Warren (1842-1927) "... the use of fuming bromine [was] recommended by many surgeons in our Northern armies during the Civil War." From *To Work in the Vineyard of Surgery*, The Reminiscences of J. Collins Warren, ed. by Edward D. Churchill, M.D., Cambridge, Harvard University Press, 1958.

John H., aged 25, private in the Hospital Guards at Lovell Hospital, was confined four hours on the night of February 28, 1863, as a punishment for bringing spirits into camp and attempting to run the guard. When released from his cell by order of the officer of the guard, he rushed upon the latter and struck him in the face. The sergeant thereupon drew his sword, stepped back a pace and put himself on guard, holding the grip of his sword firmly against his right hip with the point slightly elevated. As the ground was uneven and covered with frost, the prisoner slipped, fell on the point of the sword, and then fell heavily forward on the ground. When picked up he was insensible and breathing heavily. After the blood, which had flowed copiously about his face, was washed away, only a slight wound in the right nostril could be found. The officer of the day, an acting assistant surgeon, was summoned immediately. He could detect no other injury than the trivial one to the right ala nasae.

The patient had been drinking heavily and it was felt, not unjustifiably, that he was merely drunk, whereupon he was returned to the guard house. The next morning, still unconscious, he was removed to a ward, where he expired thirty-one hours after injury.

An autopsy was performed some nine and a half hours post mortem. A transverse fracture of the posterior clinoid process was found. The specimen was forwarded to the recently organized Army Medical Museum.

In December of 1864, it was announced that Dr. Edwards, at his own request, had been relieved of duty at the hospital. He was replaced by Dr. Charles O'Leary, who commanded the installation until its closing. Dr. Edwards, who attained the rank of brevet colonel "for faithful and meritorious service during the war" and the permanent rank of lieutenant colonel in the regular army, died on November 8, 1877. On April 25, 1864, he was elected an honorary member of the Rhode Island Medical Society, bespeaking the high regard in which he was held by his colleagues in this area.

On August 19, 1865, it was announced that the hospital was to be broken up. All summer the paying off and mustering out of large numbers of patients had been going on slowly and laboriously. In the preceding two weeks some one hundred twenty-five patients had been discharged, leaving now only twenty-five. These were eventually transferred to a government hospital in Worcester, Massachusetts. Only two surgeons had been retained. The buildings and other public property were sold at public auction shortly thereafter and the land reverted to private hands. The hospital guards, consisting now of seventy men and three officers, all combat veterans, returned to Providence on August 28 to be

mustered out of service, bringing to an official close the hospital's activities.

During its four years of activity the hospital had been a very major operation indeed. No official statistics are available as to its total census, but it was announced on May 20, 1865 (Appomattox was on April 9) that the number of patients received had reached 10,490. So far as we can determine a subsequent detachment of 103 sick and wounded were the last to arrive, bringing the total to 10,593. Of these 308 died, while over 9,000 were returned to duty or discharged. The cemetery contained 251 bodies, while 57 had been removed by relatives or friends.

We can, I think, heartily agree, some ninety years later, with the following evaluation by a contemporary observer: "The proportion who had died is very small, if we consider the sad condition in which they were received . . . and it speaks well for the officers . . . as well as for the healthiness of the location."

The only remaining business after closing of the hospital was establishment of permanent care for the cemetery. It was reported in October 1865, that the Federal government had requested the state to assume this obligation. The grounds were reported to be in excellent order, the graves numbered, and a plain fence placed around the whole. A complete registry was maintained. Governor Smith proposed to ask the next General Assembly to pass the necessary legislation, but it appears unlikely that this was ever done. No such legislation is recorded and the cemetery is no longer in existence.

The following reminiscence, written in 1898 by D. C. Denham, once a ward-master in the hospital, gives an adequate explanation: "The War is ended and as I pass by on the Fall River Railroad (Old Colony) and the conductor calls out Portsmouth! what a flood of memories it brings to mind. Looking backward (33 years ago it was) as I look from the car window all I can see of Lovell General Hospital is the grounds and all that is familiar to me is the hill at the south part of the grounds. . . . Even the graves of the dead are gone, the bodies carried to that great National Cemetery at Arlington. . . ."

Acknowledgments

The author wishes to express his sincere appreciation to all those who contributed to this endeavor, particularly to Mrs. Helen DeJong, librarian of The Rhode Island Medical Society, and to Mrs. Gladys Bolthouse, librarian of the Newport Historical Society, for their invaluable bibliographical assistance; to Miss Alice Brayton of Green Animals, Cory's Lane, Portsmouth, R. I., for reminiscences of her girlhood visits to neighboring Portsmouth Grove, and for use of the lithograph of Portsmouth Grove Hospital; to the late Miss Evelyn Chase, formerly president of the Portsmouth Historical Society, and director of public assistance of the Town of Portsmouth, for helpful advice, and particularly for the anecdote concerning the hollow tree used to convey fruit of the grain into hospital terri-

tory; to my faithful, patient and meticulous secretary, Miss Marie T. Clair; and to all those who assisted with suggestions and proofreading; including my long-suffering wife.

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The RHODE ISLAND MEDICAL JOURNAL

Owned and Published Monthly by the Rhode Island Medical Society

106 Francis Street, Providence, Rhode Island

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MR. REUTHER, LABOR HEALTH DEMANDS, and the BLUE PLANS

AT THE 17th constitutional convention of the United Auto Workers, held in Atlantic City last month, Mr. Walter Reuther, president of the union, presented his report which covered problems ranging from the details of contract negotiations to union participation in world affairs — a report that was subsequently published as a thirty-two-page magazine of tabloid newspaper size.

On the subject of health security for his workers, Mr. Reuther, bemoaning the failure of Congress and the public to embrace former President Truman's 1948 proposals for a national compulsory health insurance system, indicted the voluntary Blue Plans and commercial insurance programs. He generalizes, as is the way of politicians also, with statements such as the following: "But years of experience have demonstrated built-in inefficiencies, waste, increasing costs and an utter lack of responsiveness to consumer needs in prevailing health insurance and medical practice."

His generalization made, he proceeds to report that his union has now sponsored the development of the Community Health Association, a comprehensive prepayment medical care plan soon to be launched in the Detroit area. It will provide complete medical care on a prepayment basis furnished by physicians working in groups and based in community hospitals, and he expresses the confident hope "that this experimental program will demonstrate in very practical fashion the social, economic and medical advantages of group practice prepay-

ment plans."

"The modest and reasonable goals" for which Mr. Reuther says his union is "prepared to pay whatever reasonable cost is needed to achieve them" consist of:

1. Fully prepaid medical care unencumbered at the time of receipt of health services by economic deterrents such as deductibles — similar to deductible provisions in automobile insurance — and coinsurance.
2. Comprehensive protection for necessary health services whether performed in the hospital, home or doctor's office, and whether for treatment of illness or injury or for preventive care, diagnosis or rehabilitation.
3. Economically and efficiently organized services in medical facilities offering ready access to the full range of medical skills and specialties.
4. High standards of quality achieved by systematic and continuous review of medical practice by qualified medical authorities.

In simpler terms, it would appear that Mr. Reuther proposes a comprehensive hospital-surgical-medical care program as opposed to the Blue Plans which necessarily limit their coverages in order to take care of catastrophic illnesses mainly, and at the same time provide a premium charge within the range of the great majority of the public.

What is the "reasonable cost" that Mr. Reuther would pay for his comprehensive coverage? Sig-

nificantly, his contracts with the auto industry require industry to pay HALF the cost of the Michigan Blue Plans for not only the coverage for the worker *but also for his FAMILY*. He is also a strong proponent of national compulsory health insurance, and he would undoubtedly yield his Community Health Association on short notice to a federal program.

Mr. Reuther has a peculiar ability to define terms to suit his thinking of the moment, as was evidenced in his testimony before the House Ways and Means Committee last July. Undoubtedly his definition of "reasonable cost" could be cast to meet any given situation, confusing as the definition might be to a student of economics.

Mr. Reuther, as a Michigan resident, is well aware of the work of the Michigan Blue Plans. His leadership was effective in developing the programs in that state, and if they have "built-in inefficiencies" and waste then he should have been in the forefront with evidence and with solutions.

As a nonprofit organization the Michigan Blue Shield is under the purview of the insurance department as well as the general public. The fate of the Michigan program in recent years parallels that of similar voluntary insurance plans in other states. Inflation has devaluated our money at a time when a majority enrollment in the insurance plans has increased the utilization of hospital and allied medical services.

In 1958 the Michigan Blue Shield Plan sustained a loss of \$2,998,274. That loss was from a reserve fund, and it was paid out for subscriber benefits under a plan far more restrictive than Mr. Reuther anticipates for his Community Health Association.

Mr. Reuther maintained to the Congressional committee that "any law in a free society should make benefits available to every citizen who needs the benefits and who is willing to pay the cost of such benefits." But he considers the costs of the nonprofit Blue Plans unfavorably and he criticizes in the same breath the failure of the Plans to give even more liberal coverages.

Who will be willing to pay Mr. Reuther's "reasonable costs" which are yet to be defined? The worker? or will industry, already bearing half the tax charge as employee compensation, be bargained with for additional money to meet the "reasonable costs" which it will in turn pass along to the rest of the country in increased auto prices? Is it thus that Mr. Reuther will prove his theory that his union can run a better and more liberal health care program than the voluntary nonprofit Plans?

QUACKERY ON TELEVISION

Recent press reports concerning the rigging of quiz programs on television indicate that the television industry has had some misgivings about these rather unsavory disclosures. A spokesman for the

industry has stated that outside packaging producers "have hoodwinked the public and broadcasters whose facilities they use." He further stated that the industry "has proved, in its four decades of service, it can clean its own house when necessary." This claim apparently does not extend to its function as an advertising medium.

There is certainly no evidence that it has made any attempt to control in any effective fashion the outpouring of tawdry and misleading advertising by the patent medicine industry. The spate of hard-sell goes on unabated. There are products for "tired blood," to quench burning fires in the stomach, and to still the hammers that pound and the lightning that flashes inside the cranium. Diagrams show drugs that go 'round and 'round and come out here. Actors do before-and-after stunts which show startling restoration of vitality. Mother's aching back responds to the balm with spectacular relief. Take one pill to go to sleep, and another to stay awake. Never fear, and never see your doctor.

As we have pointed out in a prior issue [April 1959] the danger in this type of promotion lies not only in wasting money on improper, ineffective, or completely inert medication, but more seriously in postponing treatment where there may be serious disease. We might add, incidentally, that there has been no improvement in this regard in the local press. Not everything published herein is thus ignored.

THE SOCIETY REPORTS ON THE AGED

The report of the Society's Committee on Medical Economics, in which the problems of medical care for the older age population of the state are extensively reviewed, is published in this issue of the Journal. Every member of the Society should carefully read this report which the House of Delegates approved last month.

The efforts of politicians and social planners to capitalize the increasing segment of the population over the age of 65 years has created a sizable furor about the medical care of these people, as if that were the main and only problem with which they are faced. The Society's review of the issue does much to indicate that in Rhode Island at least, the physicians' role in the medical program for the older age group far surpasses in importance any efforts by other groups of individuals, or agencies, in our community.

The Society has faced up to its part of the problem, and it has clearly indicated both its ability to cope with its task, and its willingness to explore every feasible method to lessen the cost of medical care for the person with limited resources, whatever his age.

We need most at this time strong support from our elected leaders at the national, state and local levels to combat the inflation of the dollar which

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seriously affects the earning and spending economy of each of us, and which particularly robs the aged or retired worker at the time when he is in greatest need for full value on his savings or insurance investments.

Merely to rush to Washington and dip into the federal cash bags for funds to create a system of care for the aged is no solution. On the contrary, it would add chaos to the very situation it seeks to improve.

As the Society's report aptly states — "every agency and citizen should be urged to contribute positive and constructive thinking for a solution to this and other health care problems at local levels and without federal intervention and subsidy that could lead to further socialization and yielding of personal liberties."

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MEDICAL CARE FOR THE OLDER AGE POPULATION IN RHODE ISLAND

A Special Report by the Committee on Medical Economics of the Rhode Island Medical Society Approved by the House of Delegates of the Society on October 7, 1959

SUMMARY

THE EVIDENCE that older aged persons seek and receive medical care in Rhode Island, and pay for the services in full or in part, according to their means, indicates both an appreciation of the importance of our elders in maintaining good health, and at the same time a fine co-operation between the physicians and health agencies in our communities in providing medical services at reasonable cost.

Current fees charged for home and office visits by physicians are fair and reasonable by all accepted standards. Even the state Department of Social Welfare has taken cognizance of the reasonableness of the fees charged for professional medical services. Certainly no other group of individuals in our state has voluntarily come forward with a comparable contribution to the solution of the economic problem of the entire population, and particularly the older age group, as has the medical profession through its service feature of the Physicians Service insurance program.

The recommendation is advanced that the Society urge industrial concerns in Rhode Island to give favorable consideration to the hospital-surgical-medical insurance coverage, both regular and catastrophic, for employees which could continue after retirement of the worker.

The recommendation is also advanced that a permanent liaison committee be established composed of hospital administrators, hospital trustees, Blue Cross, Physicians Service and Rhode Island Medical Society representatives, that would meet regularly and maintain a lively interest in hospital costs, exploring every possible way in which they may be kept at a minimum, with particular attention to unnecessary hospitalization, the avoidance of duplication of pre-hospital services or laboratory tests and payment of pre-hospital diagnostic and laboratory procedures when followed by hospitalization, thus cutting down the duration and expense of the hospital stay.

A recommendation is made that the Rhode Island Medical Society direct an appeal to the insurance industry, through its trade associations and to the companies directly, if possible, urging that they eliminate the age requirement from their health and accident insurance coverages.

The Committee feels that every effort should be made to bring forcefully to the attention of the public in general, and to public agencies, including press, radio, and television in particular, the continuing efforts in Rhode Island to provide voluntary prepaid health care for all citizens, and particularly the older age group.

Your Committee believes that outstanding progress has been made in Rhode Island to assist the over age 65 person to meet his medical care costs, and that every agency and citizen should be urged to contribute positive and constructive thinking for a solution to this and other health care problems at local levels and without federal intervention and subsidy that could lead to further socialization and yielding of personal liberties.

Committee on Medical Economics

STANLEY D. SIMON, M.D., <i>Chairman</i>	
JOHN F. W. GILMAN, M.D.	SAUL WITTES, M.D.
CHARLES L. FARRELL, M.D.	GUSTAVO MOTTA, M.D.
JOSEPH WITTIG, M.D.	MICHAEL G. PIERIK, M.D.
EDWARD ZAMIL, M.D.	ARTHUR E. HARDY, M.D.
JAMES MCGRATH, M.D.	ALFRED L. POTTER, M.D.

In order properly to consider additional methods at local levels to assist the older age persons in Rhode Island with their medical expenses, consideration must first be given to the present health status of this segment of the population. The most recent available study is that made in 1953 by the Governor's Commission to study problems of the aged. The data on the physical health of the over age 65 persons stemming from that study presumably holds true for that age group today.

The Study Commission reported that—

1) Two thirds of the aged were well. (65% said that they were in fairly good health).

2) More than half (54%) were in good health and had no serious physical defects. In this category were found: 65% of the men and 59% of the women aged 65 to 69; 51% of the men and 53% of the women aged 70 to 74 years; 52% of the men and 41% of the women who are 75 years and over.

3) One fourth (27%) of the aged were handicapped by serious defects of vision, hearing, or mobility.

4) Of the 46% of the aged who reported them-

selves as being in poor health, 14% listed themselves entirely limited in physical activity. They are bedridden or chair bound, and they represent 6% of the total aged population, exclusive of the aged hospitalized in state institutions. (As of June 1, 1959 there were 1,890 persons over the age 65 in the state institutions. See Table I.)

5) Among 25,000 persons who reported poor health conditions, apart from physical handicaps, 43% said they were suffering from some form of cardiovascular disease. Arthritis was reported next in prevalence, affecting from 14 to 25%. Other frequently reported conditions were diabetes, kidney trouble, cancer, and general deterioration.

(For the purposes of the survey, reports of heart trouble, high blood pressure, hypertension, shock, hardening of the arteries, circulatory ailments, etc.—not mutually exclusive terms and admittedly not precise—were recorded in the category of cardiovascular disease.)

6) Better than two thirds (71%) of the aged reported that they had received medical services of one type or another during the previous year, and of this number 88% consulted a doctor one or more times, 13% were hospitalized, and 5% had nursing care at home. In the total aged population, 63% (45,000 persons) consulted a physician during the year, and 9.5% (6,800 persons) were hospitalized.

7) Among the aged who received medical care during the year, 80% (40,000 persons) reported that they paid for these services themselves, either in part or in full. (This estimate uses the term medical care as all-inclusive of physician services, hospital expense, drugs and medicine, home nursing care, and appliances.)

Another 10% reported their medical expenses paid by Blue Cross or other insurance. About 8% received medical services which were paid for through the Old Age Assistance program. One in ten had some help from relatives.

(As the Commission noted in its report, "there is no doubt that medical and hospital rates were adjusted to the means of aged persons receiving services, as they are for the population generally.")

Persons interviewed in the Commission's survey were asked: "Except for minor temporary ailments, such as a cold, would you say you are now in fairly good health?" Those who answered negatively were asked: "What is your main trouble?"

All were asked, "Do you have physical handicaps such as poor eyesight, poor hearing, or trouble getting around?" Finally, persons saying they were ill or physically handicapped were asked, "How much are your daily activities limited by your condition?"

The Commission recognized that answers to these questions did not provide a basis for evaluating health conditions of the aged in any strict sense, as any physician would readily point out. However,

the answers did give a clue to the attitude of the aged themselves as to their health and physical condition.

Several valid assumptions appear reasonable from this data.

As noted by the Commission, "one may be gratified that nearly three out of four in the total aged population are free of serious physical defects, (and) more than half (54 per cent) are in fair health and have no physical disability."

The evidence that old age persons seek and receive medical care in Rhode Island, and pay for the services in full or in part, according to their means, indicates both an appreciation of the importance of our elders in maintaining good health, and at the same time a fine co-operation between the physicians and health agencies in our communities in providing the medical services at reasonable cost.

The reports from those complaining of poor health indicate disabilities of a chronic disease nature, many of which can be alleviated with treatment, but few of which can be completely eliminated. Home and nursing care, adequate housing and proper diet, plus leisure time activities to keep the older age person occupied, offer a major challenge in the face of a chronic illness.

TABLE I
Estimated Number of Aged Persons
in Rhode Island State Institutions
(As of June 1, 1959)

	Estimated No. aged 65 and over	Population ending 6/1/59
State Hospital.....	1,140 (6/58)	3,409 33.4%
State Infirmary.....	500 (10/58)	597 83.8%
Ladd School.....	30 (7/59)	909 3.3%
Zambarano Mem. Hosp.....	80 (7/59)	303 26.4%
Adult Correctional.....	15 (7/59)	521 2.9%
Veterans' Home.....	125 (2/59)	218 57.3%
	1,890	5,957 31.7%

In round numbers you may remember this finding of 1,890 out of 5,957 by saying about 1 of every 3 of the some 6,000 in these institutions are 65 or over. You will note the great range involved too. Thus as would be expected our Adult Correctional Institutions has a small aged population (2.9%) as compared to our State Infirmary — our geriatric institution — which had 83.8% of its population in the 65 and over age group. You will note that the dates vary in terms of the time the data was available for the various institutions. However, for our purposes this is relatively unimportant.

Source: Department of Social Welfare, State of Rhode Island.

The survey indicated that in 1952 about ten per cent reported their medical expenses paid by Blue Cross or other insurance. In the intervening years Blue Cross has enrolled 70% of the people in the state who are over the age 65, and Physicians Serv-

continued on next page

ice has enrolled 50% of this group. In addition there has been a tremendous development of insurance coverage for persons over the age 65 by private insurance companies in the health and accident field.

In the intervening years the Department of Social Welfare has established its "pooled fund" whereby complete medical care is given under its public assistance program. An impartial study of the Department released in January, 1959, indicated clearly that of all groups in the state the medical profession is making the greatest contribution to aid all persons, and in particular to those receiving old age assistance, by rendering services at relatively low rates, or for no charge whatever. (See Tables II and III.)

Implementation of Report Made to the House of Delegates

Your committee has held two lengthy meetings at which reports and studies by subcommittees have been considered and evaluated. In accordance with the mandate of the House of Delegates, the Committee makes the following comment on the suggestions set forth in the report adopted by the House at the April Session and referred to the Committee on Medical Economics for study and suggestions for implementation.

TABLE II

Free Services to Public Assistance Recipients (Exclusive of GPA) in Rhode Island During 1956-57

It is clear that the quantitative standards and the fee schedules in effect are not unduly liberal. The Office of Medical Services appears to have been successful in securing the co-operation of the profession in the development of reasonable standards. The Director of Medical Services points out, too, that in addition to providing services at relatively low rates, under the regular program, many physicians give medical care for which no bills are presented. Also, they continue to render free services at hospitals which benefit the recipients of public assistance. In another connection the Director enumerated these free services to public assistance recipients (exclusive of GPA) in Rhode Island during the year 1956-57 as follows:

Services	Reasonable Fees	Total Value
46,000 hospital visits at.....	\$ 5.00	\$230,000
887 surgical	130.00	133,000
275 tonsils and adenoids	65.00	17,875
130 deliveries	130.00	50,570
42 D. & C.	62.00	2,604
29,350 O.P.D. services	3.00	88,050
Total free services to PA recipients		\$522,099

Source: Report of Special Commission to Appraise the Financial operations of the state Government and the Matter of State-Local Financial Relations. January, 1959.

Resolution I

Home and Office Fees for Older Age Persons

Your committee has noted that the current fees charged for home and office visits by physicians are fair and reasonable by all accepted standards. Even the state Department of Social Welfare has taken cognizance of the reasonableness of the fees charged for professional visits, as noted previously in this report.

As revealed in the survey of the aged made several years ago, physicians' charges are obviously in no manner a burden for the aged in this state. Our doctors have always adjusted their fees for elderly persons retired from work, or for those who live on a limited income, and we have every reason to believe that our membership will continue to give individual consideration to a patient of any age, and particularly to an older age person, in the matter of adjusting a fee that might constitute a financial hardship.

In view of the study commission's observation that "impaired vision has the highest incidence of disability," it is worthy of comment that in its review of the reasonableness of medical charges a survey report of the state social welfare department states that "the average charge for a complete eye examination, the fitting of glasses, together with lenses and frame, was \$13.

TABLE III

Comparison of Monthly Payments for Medical Care, Through Pooled Fund or Otherwise, New England States, August, 1958

State	OAA	ADC	AB	AD
Connecticut	\$20.00	\$6.09	\$16.00	\$35.00
Maine	7.50	.86	6.00	12.00
Massachusetts	19.77	3.32	1.50	33.53
New Hampshire	15.00	3.98	11.00	30.00
Rhode Island	11.00	4.38	6.00	14.00

It appears from this tabulation that expenditures for medical care in Rhode Island are decidedly reasonable compared with those in neighboring states. The director of Medical Services is convinced that the services rendered are fully as good as in other states. The relatively low expenditures he attributes to close co-operation with the professional societies which has enabled him to set standards and fees which are extremely reasonable, and to the careful supervision of the program. This supervision assures the large majority of practitioners who are willing to co-operate that the standards will be applied in all cases for the benefit of the community, and is largely responsible for the continuing support of the program by the professional groups.

Source: Report of the Special Commission to Appraise the Financial Operations of the State Government and the Matter of State-Local Financial Relations. January, 1959.

The enrollment of the older age population under the Physicians Service program — the highest by any such voluntary program in the nation — has proved anew the desire of the elderly to provide for their own health care costs, and at the same time it indicates an appreciation of the unique contribution by the doctors of Rhode Island whereby they guarantee the surgical procedure costs for persons of specified income classifications within which the great majority of retired and elderly persons undoubtedly are listed.

Under this insurance coverage, now held by more than 50% of the state's over age 65 group, the fee for the surgeon, the assistant surgeon, and the anesthesiologist is guaranteed. *No other group of individuals in our state has voluntarily come forward with a comparable contribution to the solution of the economic problem of the entire population, and particularly the older age group.*

Resolution II

Continuance of Blue Cross, and Physicians Service, and Private Insurance Company Coverage Upon Retirement

As noted previously, Blue Cross and Physicians Service in Rhode Island have for many years opened their direct enrollment campaign to persons of any age, and they have also allowed employed persons to continue their coverages in the Plans upon retirement. Earlier this year the executive director of the Plans, in a public announcement, reported that of the more than 70,000 people in the state who are over age 65, approximately 56,500 are enrolled in Blue Cross, and 41,000 are enrolled in Physicians Service.

At that time, he reported, Blue Cross had 400, and Physicians Service 300 subscribers between the ages of 90 and 99, and there were more than 5,000 in Blue Cross and nearly 4,000 in Physicians Service between the ages of 80 and 89. Benefits for these persons were not reduced in any manner because of the age of the subscriber.

Many business concerns in Rhode Island have made the continuance of Blue Cross-Physicians Service benefits part of an employee retirement program.

A recent survey of the insurance industry also indicates that a very large majority of insurance companies writing group insurance make available policies in which benefits are continued when the worker retires. Thus, at the present time this survey indicates that 51.9% of the people insured under group hospital programs have some measure of protection at the time of retirement, either through a continuance of the plan under the retirement program, or by conversion to an individual policy. In other words, half the people insured by group hospital plans of insurance companies have this protection available to them when they retire.

The survey also indicates that 31.6% of employees and dependents covered under group surgical plans written by insurance companies will have the coverage continued after retirement, and 34.7% the regular medical.

Major medical coverage is moving in the same direction. The same survey reveals that 19.4% covered under supplementary major medical coverage, and 46.4% of people covered under comprehensive major medical policies, will have such coverage continued after retirement. This is an impressive statistic inasmuch as it reveals that one out of two persons insured under group comprehensive major medical insurance will retain such coverage after retirement.

On an individual basis for major medical insurance there are at this time three companies that will issue policies after the age 65, and there are twenty companies that will renew a major medical insurance policy for life if the insured has purchased the policy prior to age 65. It is significant too, that one third of the people covered by major medical policies have contracts which are guaranteed renewable, and they will not be canceled for reason of health deterioration.

To your Committee these statistics revealing action by the insurance industry are extremely significant in that the vast majority of these programs have come about in the last five years.

Your committee recommends that the Society urge industrial concerns in Rhode Island to give favorable consideration to the hospital-surgical-medical insurance coverage, both regular and catastrophic, for employees which would continue after retirement of the worker.

Resolution III

Special Hospital Insurance for the Elderly

Your committee recognizes that the problem of hospital charges is entirely outside the jurisdiction of the medical profession. We feel that the public generally does not realize that doctors are in no way responsible for the fees charged by hospitals, and that they do not sit on the governing boards that resolve the economic issues of the hospitals. We will not attempt to report or analyze the many factors that are affecting the community's hospital bill today. The hospital cost is being increasingly underwritten through prepaid insurance. There is need for more general public education for better understanding of the economic factors that will continue to affect both the cost of hospitalization as well as the premium charges of the voluntary plans to meet that cost.

Doctor Francis B. Sargent, in his presidential address to the Society in June, pointed out that "seventy-one per cent of the hospital's expense is for wages for employees." In view of the inflation-

concluded on next page

ary era in which we currently find ourselves it is self-evident that the wage factor is a continuing vital one in the over-all cost of running a modern hospital.

Again, we are mindful of the new techniques in medical and surgical care involving hospital services, the great change in the public's conception of the use of the hospital, a change which, together with a rise in population, has resulted in a 50% increase since 1950 in the number of beds in the general hospitals in Rhode Island.

Whether a special hospital insurance coverage specifically for the elderly person at a reduced or special rate, as suggested in the House report, is feasible or possible is doubtful.

We do believe, however, that a permanent liaison committee that would meet regularly and maintain an active interest in hospital expenses should be established, composed of hospital administrators, hospital trustees, and Blue Cross, Physicians Service, and Rhode Island Medical Society representatives to explore every possible way in which hospital costs may be kept at a minimum, and duplication of hospital services or laboratory tests completed prior to admission might be avoided.

Resolution IV

Elimination of Insurance Company Cancellations Because of Age

As noted above, the insurance industry has made rapid strides in opening up its coverages to older age persons, making both regular and major medical contracts guaranteed renewable and not to be canceled because of health deterioration. Likewise, the companies have made advances in removing the age barrier for renewal of coverages.

A check of a statistical reference of the companies writing life and accident and sickness insurance indicates that 40 out of the 100 companies listed have no set age limit such as has been the practice previously, and of this group 12 list lifetime renewal coverage. This trend is most encouraging.

An estimate of current health and accident coverage for persons over age 65 sets a figure of 2,500,000 with coverage provided by insurance companies, 3,500,000 with Blue Cross-Blue Shield, and 400,000 covered under independent plans.

Your Committee recommends that the Society direct an appeal to the insurance industry, through its trade associations and to the companies directly, urging that they eliminate the age requirement from their health and accident insurance coverages.

Resolution V

Public Co-operation for Comprehensive Health Plans

Your Committee feels that every effort should be made to bring forcefully to the attention of the public in general, and to public agencies, including the press, radio, and television in particular, the efforts in Rhode Island to provide voluntary prepaid health care for all citizens, and particularly the older age group.

In August of this year the Health Insurance Institute reported the number of persons in Rhode Island with health insurance increased by 5,000 last year to reach a total of 706,000 at the end of 1958. Thus, it reported, some 83.1% of the state's estimated current population now have some form of health insurance designed to help pay hospital and doctor bills. This survey, based on reports of insurance programs of insurance companies, Blue Cross-Physicians Service and other health care plans, also indicated that the number of persons with surgical expense insurance is an estimated 597,000, and persons protected by regular medical expense insurance, providing for doctor visits for non-surgical care, increased to a total of 556,000 by the end of 1958.

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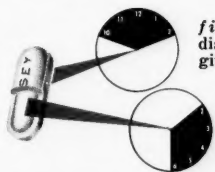
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HOUSE OF DELEGATES *of the* RHODE ISLAND MEDICAL SOCIETY

Report of Meeting Held October 7, 1959

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library in Providence on Wednesday, October 7, 1959. The meeting was called to order by the president, Doctor Alfred L. Potter, at 8:00 P.M. The following delegates were in attendance:

BRISTOL COUNTY: Robert W. Drew, M.D.
KENT COUNTY: Peter C. Erinakes, M.D.; Donald K. O'Hanian, M.D.
NEWPORT COUNTY: Anthony T. Carrellas, M.D.; Philomen P. Ciarla, M.D.
PAWTUCKET DISTRICT: Robert C. Hayes, M.D.; Alexander Jaworski, M.D.; Harry Hecker, M.D.
WASHINGTON COUNTY: James McGrath, M.D.; Samuel Farago, M.D.
WOONSOCKET DISTRICT: Joseph A. Bliss, M.D.
OFFICERS OF THE RIMS (other than delegates): Alfred L. Potter, M.D. (president); Earl J. Mara, M.D. (president elect); Arthur E. Hardy, M.D. (secretary).
IMMEDIATE PAST PRESIDENT OF RIMS: Francis B. Sargent, M.D.
PROVIDENCE MEDICAL ASSOCIATION: Irving A. Beck, M.D.; Alex M. Burgess, Jr., M.D.; Bertram H. Buxton, Jr., M.D.; Wilfred I. Carney, M.D.; Francis H. Chafee, M.D.; Michael DiMaio, M.D.; Henry B. Fletcher, M.D.; Frank Fratantuono, M.D.; J. Merrill Gibson, M.D.; John F. W. Gilman, M.D.; Seebert J. Goldowsky, M.D.; John C. Ham, M.D.; Walter S. Jones, M.D.; Joseph G. McWilliams, M.D.; William S. Nerone, M.D.; Francis W. Nevitt, M.D.; Arnold Porter, M.D.; William A. Reid, M.D.; Ralph D. Richardson, M.D.; Stanley D. Simon, M.D.

Delegates without voting power present were Jeremiah A. Dailey, M.D., State Health Department director, and Charles J. Ashworth, M.D., delegate to the A.M.A.

Also present was Charles L. Farrell, M.D., secretary of the Rhode Island Medical Society Physicians Service and John E. Farrell, Sc.D., executive secretary.

Report of the Secretary

Doctor Arthur E. Hardy, secretary, noted that his report had been submitted to the delegates in the handbook. There was no discussion of the report.

Action: It was moved that the report of the secre-

tary as submitted be approved and placed on file. The motion was seconded and adopted.

Report of the President

Doctor Alfred L. Potter, president, reported briefly on the preliminary plans for a sesquicentennial Celebration Committee for the Society, indicating some of the projects that such a Committee might undertake.

He briefly discussed the hearings on the Forand Bill to extend Social Security benefits to include hospital and surgical care.

He reported on the relative value study meeting held in Boston in July under the auspices of the American Medical Association.

He also reported on the conference on aging sponsored by the New England Medical Societies, the New York State Medical Society, and the American Medical Association. He noted that Doctor Alex M. Burgess, Sr., would be chairman of the Rhode Island conference to prepare the state's report for the White House Conference on Aging, to be held in 1961.

Report of the Treasurer

In the absence of Doctor Beardsley, treasurer, Doctor Hardy noted that the budget drawn by the treasurer had been approved by the Council and was included in the delegates' handbook.

Action: It was moved that the budget proposed for 1960 be approved. The motion was seconded and adopted.

Recommendations from the Council

The secretary noted that there were two recommendations submitted by the Council to the House of Delegates:

1. The Council recommends to the House of Delegates that the Society's official representatives on the Board of Directors of the Rhode Island Blue Cross for the fiscal year starting with the annual Blue Cross meeting in 1960 be: Charles J. Ashworth, M.D., and Charles L. Farrell, M.D.

Action: It was moved that the recommendation be adopted. The motion was seconded and passed.

2. The Council recommends that the 1960 dues

assessment for active members more than one year in practice be \$50, and for members in their first year of practice, \$25.

Action: It was moved that the recommendation be adopted. The motion was seconded and passed.

The Rhode Island Plan

The Rhode Island Plan with insurance companies was discussed by members of the House, after which the following actions were taken:

It was moved that the House of Delegates of the Rhode Island Medical Society discontinue the Rhode Island Plan.

The motion was seconded and passed.

* * *

It was moved that the secretary of the Society be instructed to notify all insurance companies approved under the Rhode Island Plan as soon as feasible, but within thirty (30) days, of the Society's termination of the Plan.

The motion was seconded and adopted.

Benevolence Fund

The president noted that the report of the Benevolence Fund was included in the handbook. He urged that all district societies encourage their members to support this fund.

There was discussion of the report.

Action: It was moved that the Rhode Island Medical Society send a request at the time the annual dues is assessed the membership asking for a voluntary contribution by each member to the Benevolence Fund of the Society. The motion was seconded and adopted.

Committee on Tenure of Officers

Doctor Stanley D. Simon, chairman of the special committee on tenure of officers and other officials nominated or elected by the Society, submitted his report, copy of which was included in the handbook to the delegates.

The recommendations of the Committee were discussed by the members of the House. Doctor Potter noted that the intention of the Committee was that the acceptance of the recommendations by the House would not make the actions retroactive.

Action: It was moved that the report be accepted and the recommendations adopted. The motion was seconded and passed.

Social Security Poll

The president noted that the final results of the poll of the membership on social security coverage had been included in the handbook for the information of the delegates. He noted that a copy of these results had been submitted to the secretary of each district society.

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Veterans Affairs

The secretary noted that the report of the Committee on Veterans Affairs was included in the handbook. The report was discussed by members of the House.

Action: It was moved that the House refer the report back to the Veterans Affairs Committee for further study relative to action by other state medical associations regarding federal medical care to veterans, and for further clarification of the recommendations it had submitted to the House. The motion was seconded and passed.

Medical Defense and Grievance

Doctor Francis B. Sargent, chairman of the Committee on Medical Defense and Grievance, gave an oral report on the work of his Committee.

National Legislation

Doctor William A. Reid reviewed the action taken in Rhode Island on national health legislation and he reported in detail on the conference held in St. Louis on October 2 and 3 under the sponsorship of the American Medical Association. He discussed the various situations anticipated in 1960 in view of the fact that this will be an election year.

Committee on Medical Economics

Doctor Stanley D. Simon submitted a lengthy report from the Committee on Medical Economics which answered the request of the House of Delegates for implementation of the recommendations submitted to it at the April, 1959 meeting relative to medical care for the older age group.

Action: It was moved that the report of the Committee on Medical Economics as submitted be received and the recommendations therein be approved. The motion was seconded and adopted.

* * *

It was moved that the report of the Committee on Medical Economics be released to the public at the earliest convenience of the chairman and the executive office. The motion was seconded and adopted.

* * *

It was moved that the Committee on Hospital and Professional Relations of the Society and the Chairman and two other members of the Medical Economics Committee selected by him be the Society's delegates to implement the recommendation in the report of the Committee on Medical Economics regarding the establishment of a permanent liaison committee to study the costs of hospitalization. The motion was seconded and adopted.

Diabetes Committee

In the absence of the Chairman of the Diabetes Committee, the executive secretary reported briefly that the Committee plans an intensive educational

RHODE ISLAND MEDICAL JOURNAL

campaign the week of November 16 and a Diabetes Fair will be planned for Monday, November 16.

Miscellaneous Reports

The president noted that an outstanding comprehensive report had been prepared by a special committee of the Rhode Island Chapter of the American Academy of Pediatrics, and the Child-School Health Committee of the Society, for submission to the governor's committee for the 1960 White House Conference. He noted that a copy of this report had been sent to each delegate.

A summary on state programs providing medical care for welfare recipients was also submitted to each delegate for information.

Adjournment

The business of the House was completed at 10:24 P.M. and the president declared the meeting adjourned.

Respectfully submitted,
ARTHUR E. HARDY, M.D., *Secretary*

REPORT OF THE SECRETARY

At meetings since the April meeting of the House of Delegates the Council of the Society:

Approved of the appointment by the president of Dr. Alex M. Burgess, Sr. as the Society's official delegate to the New England Postgraduate Assembly planning committee.

Authorized the chairman of the Child-School Health Committee to communicate with the membership of the Society urging an active educational campaign for polio inoculations in the doctor's office, to be done at a fair and reasonable fee, and to be done with no charge for the services for any family that indicated it could not pay.

Expressed its opinion that there is no need at this time for public clinics for polio inoculations except for the indigent.

Approved of the investment of \$1,000 left the Society under the will of Doctor Frederick T. Rogers to establish the F. T. Rogers Fund.

Named Doctors Alfred L. Potter, Samuel Adelson, and Arthur E. Hardy as the Society's voting delegates to the Council of the New England State Medical Societies for the fiscal year 1959-1960.

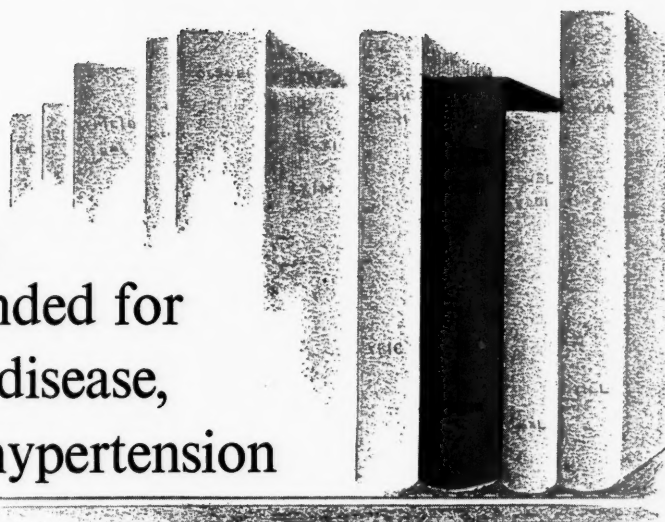
Appointed Doctor Richard Kraemer as the Society's official delegate to a Washington meeting of the Joint Council to Improve the Health Care of the Aged.

Named Doctor John T. Barrett as the Society's delegate to the A.M.A. sponsored National Conference on Physicians and Schools to be held in Highland Park, Illinois, in October.

Reviewed a poll of the membership on social security coverage for physicians and instructed the Secretary to notify the secretary of each district society of the results of the poll.

concluded on page 758

text book
recommended for
coronary disease,
essential hypertension



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A product or treatment must survive the test of clinical usefulness before it is admitted to the pages of authoritative text books.

Theobromine Sodium Acetate (often by its trade name Thesodate) is regularly included in standard text books for classical therapy of coronary heart disease, essential hypertension and for diuresis.*

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Thesodate 0.5 Gm. ($7\frac{1}{2}$ gr.)

with phenobarbital 30 mg. ($\frac{1}{2}$ gr.)

or with phenobarbital 15 mg. ($\frac{1}{4}$ gr.)

Thesodate 0.25 Gm. ($3\frac{3}{4}$ gr.)

with phenobarbital 15 mg. ($\frac{1}{4}$ gr.)

Thesodate 0.3 Gm. (5 gr.)

with potassium iodide 0.12 Gm. (2 gr.)

and phenobarbital 15 mg. ($\frac{1}{4}$ gr.)

R.S. Thesodate 0.5 Gm. ($7\frac{1}{2}$ gr.)

with Rauwolfia Serpentina 50 mg. ($\frac{3}{4}$ gr.)

*Paul Dudley White, "Heart Disease" 1951
(Macmillan) page 480;

William D. Straud, "Current Therapy," 1955
(W. B. Saunders) page 102;

Cecil & Loeb's Textbook of Medicine, 1955
(W. B. Saunders) page 1,326;

Wilson & Gisvold, "Textbook of Organic Medicinal and Pharmaceutical Chemistry," 1956
(Lippincott) page 262;

Goodman & Gilman, "The Pharmacological Basis of Therapeutics," 1941 (The Macmillan Co.)
page 281;

Albrecht, "Modern Management in Clinical Medicine," 1946 (Williams & Wilkins) page 254;

Friedberg, "Diseases of the Heart," 1956 (Saunders)
page 285;

Walter Modell, "Drugs of Choice," 1958-1959
(C. V. Mosby) pages 100, 475, 615.

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HOUSE OF DELEGATES

concluded from page 756

Referred to the Committee on Social Welfare for study communications relative to the licensure of nursing homes in Rhode Island.

Was informed by the trustees of the Caleb Fiske Fund that a Fiske Prize Essay Competition will not be held for 1959.

Approved of the decision of the president to appoint Doctor Robert Drew of Warren as trustee-at-large on the Board of Trustees of the Medical Library Building for the year 1960.

Authorized a donation of \$50 to aid the work of the National Society for Medical Research, and \$200 to assist the North East Blood Bank Clearing Bureau, maintained by the Blood Banks Association of New York.

Named Doctor William A. Reid and the executive secretary to represent the Society at a National Legislative Conference to be held in St. Louis in October.

Acknowledged a \$200 contribution to the Benevolence Fund from the Woman's Auxiliary of the Society.

Approved of the budget proposed by the treasurer for 1960, and of the assessment of dues to meet the proposed budget.

Referred to the Committee on Medical Economics for study and possible report to the House the subject of a Relative Value Schedule.

Agreed that the Sesquicentennial year of the Society should be celebrated from the time of the Annual Meeting in 1961 until the Annual Meeting in 1962.

ARTHUR E. HARDY, M.D., *Secretary*

BENEVOLENCE FUND

The Benevolence Fund had a cash balance in the savings department of the Industrial National Bank in Providence on January 1, 1959, of \$3,991.14.

The Providence Medical Association made a special appeal to its membership in January at the time the annual dues were assessed, and the Washington County Medical Society did likewise. As the result of these actions, many physicians made individual contributions to the Fund. In addition the Woman's Auxiliary and the Medical Bureau of the Providence Medical Association made contributions.

The Fund, as of October 1, 1959, had received contributions in 1959 in the amount of \$3,775.00, and with savings account interest of \$76.40, the total receipts to this date amounted to \$7,842.54.

Donations to aid physicians during 1959 have amounted to \$1,500, leaving a cash balance of \$6,342.54 as of October 1.

The trustees have also voted to provide family Blue Cross and Physicians Service coverage to

RHODE ISLAND MEDICAL JOURNAL

assist four physicians who have been unable to practice because of serious illness resulting in financial hardship.

The trustees urge every member of the Society to include the Benevolence Fund as a foremost agency to receive a contribution annually. Money given to the Benevolence Fund is tax deductible.

Respectfully submitted,

Trustees of the Benevolence Fund:

DAVID FREEDMAN, M.D.

GEORGE W. WATERMAN, M.D.

HENRY J. HANLEY, M.D.

SPECIAL COMMITTEE ON TENURE OF OFFICERS, COMMITTEE CHAIRMEN, DELEGATES AND OTHER OFFICIALS NOMINATED OR ELECTED BY THE SOCIETY

This committee, authorized by the House of Delegates at its April meeting, 1959, and subsequently appointed by the president of the Society, reviewed the by-laws of the Society and the procedures and rules and regulations governing the election, nomination, or appointment of members of the Society to represent the Society officially.

The Committee does not believe that the by-laws should at this time be amended. Rather, it recommends to the House of Delegates that the House adopt as a stated policy the following recommendations:

1. That the secretary and the treasurer of the Society, elected annually, serve not more than five successive terms.
2. That the delegate to the House of Delegates of the American Medical Association, elected bi-annually for a two-year term, serve not more than three successive terms.
3. That a member shall not serve for more than three (3) successive terms as chairman of the same Standing or Appointed Committee.
4. That no member shall be nominated for more than two (2) successive three-year terms to the board of directors of the Rhode Island Medical Society Physicians Service.

Respectfully submitted,

Committee on Tenure of Office

SAMUEL ADELSON, M.D.

IRVING A. BECK, M.D.

FERDINAND S. FORGIEL, M.D.

HENRI E. GAUTHIER, M.D.

EDMUND T. HACKMAN, M.D.

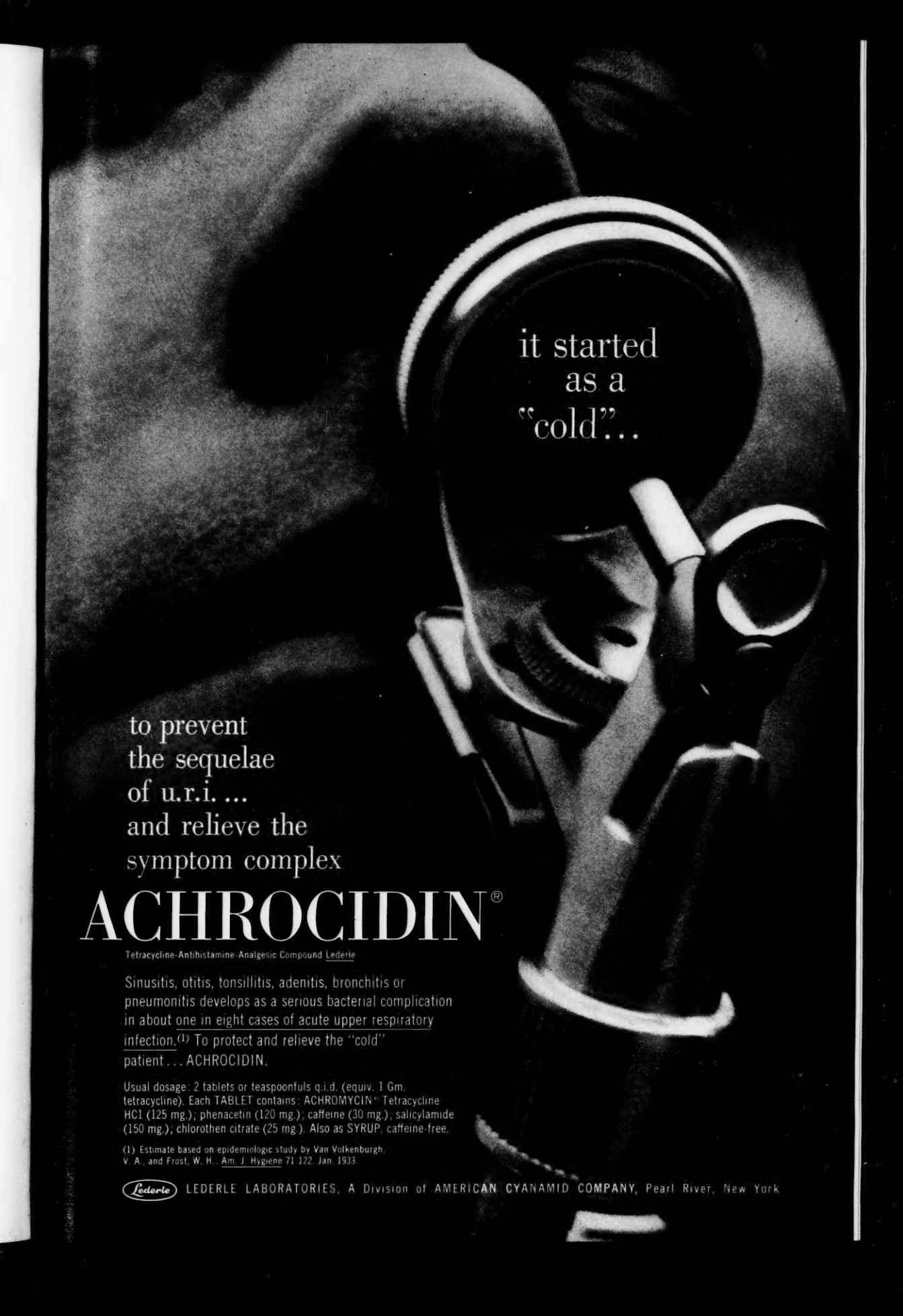
JAMES A. McGRATH, M.D.

JOHN C. HAM, M.D.

STANLEY D. SIMON, M.D., *Chairman*

ALFRED L. POTTER, M.D.

ARTHUR E. HARDY, M.D.



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(1) Estimate based on epidemiologic study by Van Volkenburgh, V. A., and Frost, W. H., *Am. J. Hygiene* 71:122, Jan. 1933.



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THE WASHINGTON SCENE

(A Report Prepared by the Washington Office
of the American Medical Association)

THE U.S. Chamber of Commerce and two key Congressmen, all opponents of the so-called Forand bill, recently issued separate warnings that an all-out effort will be made to get the controversial legislation through Congress next year.

In its weekly report to members, the Chamber predicted there will be "a powerful attempt" in the next session of Congress to enact the bill (H.R. 4700) which would increase social security taxes to help pay for the cost of the Federal government providing surgical and hospital care for social security beneficiaries.

The Chamber warned that passage of the legislation would mark "a major break-through into the welfare state." It "probably would lead to a compulsory Federal program providing complete medical care for everyone," the Chamber said.

There would be "no stopping" of such a program once it got started, the report said.

The Chamber called upon communities to find orderly solutions to the problems of the aging. Otherwise, solutions "will surely be imposed from Washington," the report added.

Similar warnings were voiced by Reps. Richard M. Simpson (R., Pa.) and Thomas B. Curtis (R., Mo.), key members of the House Ways and Means Committee where the bill was put on the shelf last session.

Rep. Curtis urged that the medical profession and other leading opponents make a strong counter-drive in an all-out effort to block passage of the bill next session. Unless there is such action, he said he would have to "regretfully" predict that legislation along the lines of the pending bill probably will be enacted in 1960.

Rep. Simpson said that H.R. 4700, and similar legislation affecting the medical profession, "make it imperative that every doctor keep informed on legislative issues before Congress." He also urged that physicians "become patriotic political forces" by giving "their informed viewpoint" to lawmakers at all levels of government.

Rep. Simpson said it "is important" that opponents of H.R. 4700 develop "appropriate alternatives" to solve the health care needs of the aged.

He promised to continue to co-operate with the medical profession to guard "against the disastrous consequences of compulsory national health insurance.

"House Democratic Leader John McCormack of Massachusetts expressed hope that Congress next year will stamp final approval on another bill of particular interest to physicians. He praised the Keogh-Simpson bill (H.R. 10) as 'meritorious legislation' and said it 'should be enacted into law next year.'" The measure, which was passed by the House last spring but left hanging in the Senate Finance Committee, would provide income tax deferrals for self-employed persons setting aside money for private retirement plans.

A National Republican Committee on "Program and Progress" proposed a far-reaching health program to be carried out by the Federal government in partnership with states and local governments.

Its goals would include: enlarging the capacity of medical schools so that 3,000 more doctors could be graduated each year, providing more hospital and nursing home beds, and supplementing hospital facilities with clinics, day-care centers and more visiting nurses to care for patients in their own homes.

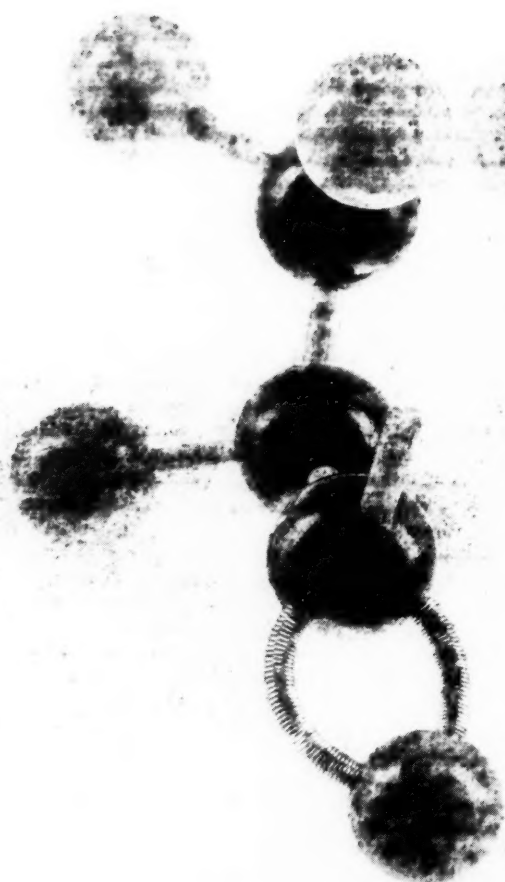
The progress of medical science would be furthered by continued Federal support for basic medical research. But such Federal support would be given under conditions to encourage maximum non-Federal spending on medical research and to prevent "too great a diversion . . . of doctors required for the equally urgent needs of teaching and medical practice." It was estimated that expenditure of \$1 billion a year — equally divided between the Federal Government and non-Federal sources — would be required by 1965.

Other recommendations included: vigorous Federal support of preventive health programs, and expansions and greater flexibility of voluntary health insurance programs.

"A free people and a free medical profession can achieve these goals with the wise support of government, without bureaucratic restrictions or interference with the physician-patient relationship which has made American health services a model for the free world," the Republican Committee stated.

The Committee proposed a five-point "partnership" program: 1) short-term Federal aid for construction of medical school buildings, 2) changes in the present hospital construction program to encourage renovation and repair of outmoded hos-

concluded on page 779



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*the Microscope*

Hospital Admissions Rise as Length of Stay Drops

In the last twenty years the rate of hospital admissions in this country has greatly increased for almost all diagnostic conditions. Today's hospital patient, however, usually goes home much sooner.

These contrasting trends in the use of general hospitals were analyzed recently by Health Information Foundation.

The Foundation compared data from U.S. Public Health Service studies from 1928 to 1943 with hospital-admission data for July 1957-June 1958 derived from the Public Health Service's current National Health Survey.

During the twenty-year period, the Foundation reported, hospital utilization increased by about 20 per cent, from 715 to 851 patient-days per 1,000 population. The average American now spends almost one day for each year of life in a general hospital.

The trend in utilization results from two factors: a rise of almost 80 per cent in admission rates (from 56 to 99 admissions per 1,000 population) partly offset by a decrease of about one-third (from 12.5 to 8.6 days) in the average length of stay per patient.

The increase in admissions resulted largely from the growth in hospitalization for obstetrical reasons. Twenty years ago, the Foundation said, less than 40 per cent of all babies born in this country were delivered in hospitals. Now, with infant and maternal mortality at all-time lows, the figure is about 95 per cent. Obstetrical cases had little effect on the increase in total days of care, though, since average length of stay per patient dropped from 10.1 to 4.4 days.

The Foundation found that admission rates for two common surgical procedures, tonsillectomies and appendectomies, declined by more than half during the period studied. At the same time, admission rates for most other operative procedures increased; for example, the rates quadrupled for surgical patients with ulcers, hemorrhoids, and

heart diseases. These changes, the Foundation noted, undoubtedly resulted from the use of modern medical techniques, such as new surgical procedures and drugs.

Although admissions rose sharply in all adult age groups, the hospitalization rate for children under 15 actually dropped — mainly because of the decline in tonsillectomies and appendectomies.

Tinted Devices Declared Detrimental to Night Driving

The use of any night driving lens or windshield, whether tinted, reflecting or polarizing, has been condemned by the Committee on Industrial Ophthalmology of the American Medical Association's Council on Industrial Health.

The committee — whose concern is the functions and diseases of the eye as related to industry — delivered its opinion in the October 17 issue of the A.M.A. Journal, after receiving many inquiries.

Its opinion is:

— That a night driving lens or windshield reduces the light transmitted to the eye, and actually makes seeing at night more difficult.

— That the source of night driving glare is the contrast between the headlights of oncoming cars and the darker surroundings. This contrast is not reduced by the use of tinted lenses or windshields. Instead, they really reduce the intensity of illumination from both the headlights and the surroundings. This impairs vision.

— That there is no scientific evidence to support any claim that the use of tinted lenses or windshields improves night vision.

Northeast Tops in Health Coverage

The Northeast region leads the nation in health insurance coverage, the Health Insurance Institute reported in October.

The nine states comprising the Northeast boast a greater percentage of population with health insurance than the nation's other three regions — the Midwest, the West and the South. And one of the region's states, New York, surpasses all other states in this field.

Some 36 million persons in New York, New Jersey, Pennsylvania, Connecticut, Rhode Island, Massachusetts, Maine, Vermont, and New Hampshire have health insurance out of the region's total population of 43 million, for a leading figure of 84.1% covered. Based on a total of 123 million persons with health insurance out of a national population of nearly 174 million at the end of 1958, some 71% of the people in the U.S. are insured against medical care costs.

The percentage for New York State, where 14.7 million persons out of 16.3 million have health insurance, is 90.5%. This is only slightly ahead of the No. 2 state, Connecticut, which has 89.5% coverage based on two million insured out of a possible 2.3 million.

Ohio is the leading state in the Midwest with a figure of 86.3%, trailed by Illinois (83.0%) and Michigan (79.9%). Colorado tops the West with 70.7%, followed by Washington (67.0%) and California (66.7%).

The leading state in the Southern regional grouping is Delaware with 75.8%. Other top states in the area are West Virginia (71.8%), Oklahoma (66.9%), Maryland (64.1%) and Tennessee (62.0%).

The state with the lowest coverage figure is Alaska with 24.6%. Hawaii has 42.2%.

Completing the roll of states with 75% coverage or better are Pennsylvania (86.7%), RHODE ISLAND (83.2%), Vermont (81.0%), Massachusetts (77.8%), Minnesota (77.7%) and Indiana (75.0%).

Poison Control Center Established for Rhode Island

Since October 1 Rhode Island has had its own Poison Control Center, based at Rhode Island Hospitals. Established under the joint auspices of the hospital and the state Department of Health, the center is staffed on a twenty-four-hour basis to give doctors and hospitals speedy and up-to-date information concerning the ingredients in any of some 700 trade name drugs and products used in the home that could be a source of human poisoning. Previously the nearest such center was in Boston.

Hospitals Alerted to Prepare for Nuclear Accidents

The nation's hospitals have been warned to get ready to handle victims of nuclear accidents which can be expected to result from increased peacetime use of the atom.

The warning came from a panel of authorities, including the medical directors of the Oak Ridge and Brookhaven National Laboratories.

In a report issued by Medical Nuclear Consultants, Inc., the experts set minimum facilities,

equipment and personnel training standards for hospital nuclear emergency programs.

At present, no nongovernmental hospital in the country is ready to provide adequate examinations for persons suspected of contamination or to care for more than a very few nuclear casualties at a time, according to the report.

But, the experts added, many hospitals could develop adequate nuclear accident programs without major construction or capital expenditure.

"Many of the facility and equipment needs for the care of radiation victims can be met with the standard resources of the average well-planned and operated institution," according to the report. "A functional prerequisite is a comprehensive emergency plan providing for the availability of these resources in time of need, but allowing for their routine utilization — in diagnosis, therapy and research — at other times."

Recommending that hospitals carry out continuing training programs for physicians and technicians who ultimately might be responsible for handling nuclear casualties, the report says, "The realistic approach to the nuclear emergency problem involves continuous daily training and experience rather than beginning after a radiation accident."

Declaring that "there is sufficient justification" for planning and preparing facilities for care of radiation exposure victims, the report points to nuclear accidents which have occurred at Argonne, Los Alamos, Oak Ridge, Chalk River and in England, Russia and Yugoslavia.

The report says that hospitals should anticipate "emergency situations" in the following areas: the nuclear reactor program, with about 370 reactors under construction or definitely planned in the United States; power reactors in use by or planned by the Armed Forces and maritime service; nuclear weapons being transported or stockpiled; fissionable materials and waste materials being transported from reactor to processing plant, and general use of radioactive materials in industry, medicine and research.

"The probability of radiation injury associated with each of these areas of nuclear use is small on the basis of individual cases," the authorities state. "Nevertheless, the sum total of these probabilities adds up to an increasingly significant hazard threat as nuclear materials are handled in ever larger quantities and more diverse circumstances."

Among nuclear emergency facilities required by hospitals, according to the report, are a receiving ward or suite capable of handling contaminated persons, with complete facilities for their decontamination; whole body radiation counter; examination and surgical rooms; a hematology section; a radioassay laboratory; patient care rooms; adequate bone marrow, blood and drug reserves. Optional addi-

continued on next page

tional facilities for research and training include a total body irradiation facility and a medical reactor, both of which would also have everyday diagnostic, therapeutic, research and training applications in the hospital.

Facility and equipment costs, depending on anticipated patient load and the extent of optional research and training facilities, would range from \$50,000 to \$500,000, according to the report. A medical reactor would cost an additional \$500,000.

Graduate Fellowships in Industrial Medicine

The University of Cincinnati's Institute of Industrial Health is offering graduate fellowships in industrial medicine. The Institute, which is in the College of Medicine, provides professional training for graduates of approved medical schools who have completed at least one year of internship.

The three-year program leading to the degree of Doctor of Industrial Medicine satisfies the requirements for certification in occupational medicine by the American Board of Preventive Medicine. Two years are devoted to intensive academic and clinical study in the field of industrial medicine. A third year is spent in residency in an industrial medical department or in some comparable organization.

Stipends for the first two years vary from \$3,000 to \$4,000 depending upon marital status. In the final or residency year the fellow is compensated by the organization in which he is completing his training.

RHODE ISLAND MEDICAL JOURNAL

Weight Tables Change as the Result of New Study

Women weigh distinctly less than a generation ago, while men tend to be heavier than their fathers.

This is just one of many significant findings of the largest statistical investigation undertaken in the health field, published last month by the Society of Actuaries under the title *1959 Build and Blood Pressure Study*.

The new average weights developed will change the tables now used on weighing machines and in doctors' offices, which were based on an actuarial study of thirty years ago.

The weights of women in their twenties average at least five pounds less than three or four decades ago. In fact, women of all ages now tip the scales several pounds lower. This is partly due to lighter clothing but reflects mainly the established vogue of slenderness that has outmoded Lillian Russell as the ideal figure.

In contrast, the average weights of short and medium height men in their twenties and thirties are now about five pounds higher. The increase in men's weights at other ages and also for tall men has been generally smaller. While the proportion of overweights has changed little over the years in both sexes, the proportion of men who are underweight has diminished, while the proportion of underweight women has increased appreciably.

Average weights for both men and women increase with advance in age through the fifties. However, the pattern of the increases in weights is different in the two sexes. Men start putting on weight in the twenties and level off in the forties, but women stay slim into the thirties and do not usually start putting on weight until after the mid-thirties.

Surgeons to Meet in Boston in February

The American College of Surgeons has announced a four-day Sectional Meeting for surgeons and nurses to be held in Boston from February 29 through March 3. Dr. Claude E. Welch is local

concluded on page 770



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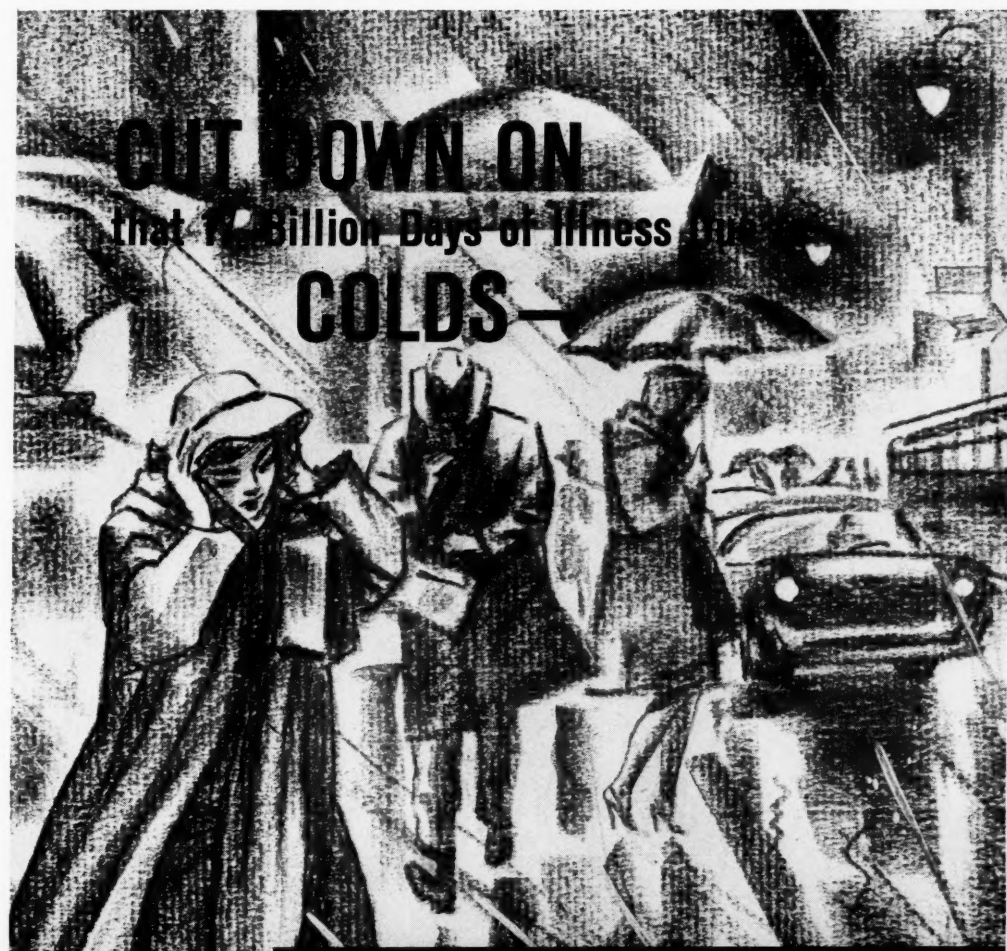
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*provide
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full range of
cold symptoms*

PROTECTION from Nasal Stuffiness

Neo-Synephrine HCl, 5 mg. — first choice in decongestants.

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PROTECTION from Allergic Symptoms

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PROTECTION from Lassitude, Depression

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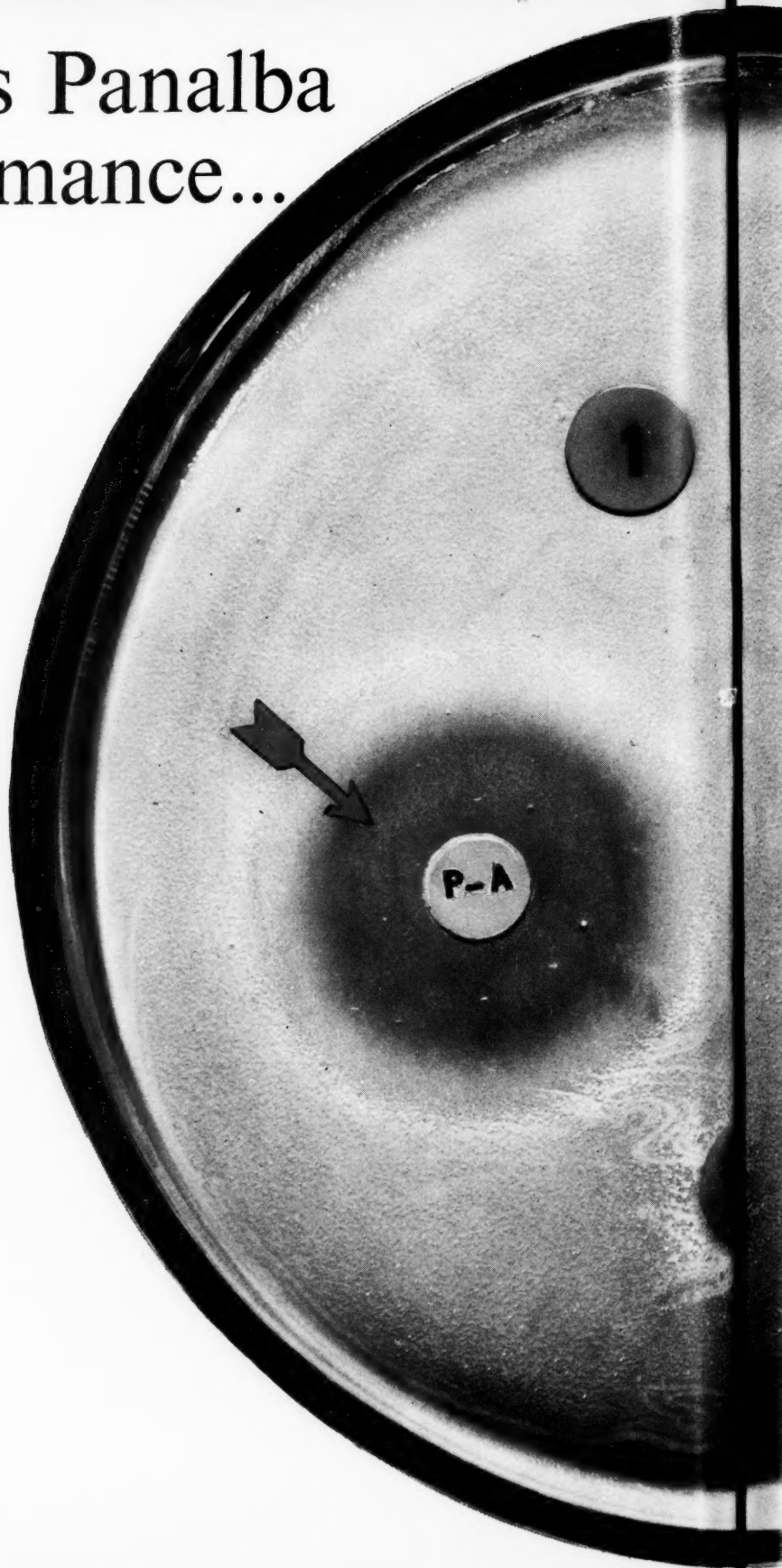
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The real issue is not the specific provisions of the Forand Bill, but rather the basic principle involved. Any Forand-type legislation would raise the same danger. It would add service benefits to a Social Security program which so far has been limited to cash payments based on the "floor-of-protection" concept.

This new principle, as you know, would alter the nature of the Social Security program. It would pave the way for evolution of a system of tax-paid health care for the entire population. Every two years—in the even years of federal elections—the push for amendment and expansion would be under way. The continuing trend would first undermine, and eventually destroy, our system of voluntary health insurance and the private practice of medicine.

... LOUIS M. ORR, M.D., *President of the American Medical Association*, speaking before the 68th annual meeting of the Association of Life Insurance Medical Directors of America, at New York, October 22.

**PATRONIZE
JOURNAL
ADVERTISERS**

**RHODE ISLAND MEDICAL JOURNAL
THROUGH THE MICROSCOPE**

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chairman of the program for the surgeons which will be presented at meetings at the Statler-Hilton hotel.

Barbiturate Addiction More Damaging

Addiction to barbiturates is more damaging to a person than addiction to heroin and other opiates, according to the current issue of *Patterns of Disease*, a Parke, Davis & Company Publication for the medical profession.

"The barbiturate addict," says *Patterns*, "is more disabled than the opiate addict in terms of thinking, judgment, reaction time, and general intellectual functioning." Moreover, barbiturate withdrawal "unless properly managed, may result in death."

How many barbiturates addicts are there in the United States? The numbers are not known, since these drugs do not come under the control of the Federal Bureau of Narcotics. But the annual consumption of barbiturates in this country is an estimated 300 tons. And more people die from taking barbiturates, either accidentally or intentionally, than any other poison.

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Better Health Care for More People Through

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NEW HATTIE IDE CHAFFEE HOME IN EAST PROVIDENCE

ON March 12, 1947, Mr. Walter Chaffee of East Providence gave to the Rhode Island Cancer Society, in memory of his mother, Hattie Ide Chaffee, a dwelling house to be used as a home for cancer patients. The state cancer society completely renovated the house to make it suitable for a nursing home, and many local community organizations and groups donated hospital beds and other equipment. A total bed capacity of fourteen was realized, and through the years there has been a continuous waiting list of patients seeking admission.

A reorganization was effected that placed the home under the administration of a nonprofit corporation distinct from the state cancer society. In view of the demand for bed space the new governing board purchased a sizable tract of land on Wampanoag Trail in April, 1957, and initiated a public drive for funds for the erection of a new hospital.

Below is pictured the new Hattie Ide Chaffee Home which will accommodate forty-five patients in a specially designed modern facility. The new

home, to be opened about the first of January, also includes a superintendent's suite, rooms for the cook and for the building custodian, a general office and waiting room, a doctor's conference room, and a large lounge, a hobby room, and a chapel for use by the patients. In a basement room space is provided for laboratory and X-ray facilities.

The medical care at the present home has been carried on by four physicians who are engaged in private practice in East Providence. This staff will be increased for the new home, and in addition any member of the Rhode Island Medical Society may send patients to the Home, and care for them himself in co-operation with the official staff.

Notice of the days for public inspection of the new Hattie Ide Chaffee Home will be widely publicized in the very near future, and the trustees of the Home particularly extend to the members of the Rhode Island Medical Society their invitation to visit Rhode Island's newest facility for the care of cancer patients.



New Hattie Ide Chaffee Home to be opened in East Providence about the first of January for care of cancer patients.

BOOK REVIEWS

PREVENTIVE MEDICINE. Principles of Prevention in the Occurrence and Progression of Disease. Edited by Herman E. Hilleboe, M.D., and Granville W. Larimore, M.D. W. B. Saunders Company, Phil., 1959. \$12.00

This is an excellent book on public health and preventive medicine for the public health physician as well as the private practitioner for whom it was primarily written. It was edited by the Commissioner and the Deputy Commissioner of Health of the State of New York. The various chapters were contributed by the staff of the New York State Health Department. It is a very practical book, written by a staff who not only are teachers but also practicing public health officials. It is compact and the authors are to be commended for their brevity. As a result, the reader gets only the essentials of the various subjects.

Perhaps the philosophy of the editors is best stated in the introduction as follows "There is much in this book to interest the private practitioner. He will discover that he and the public health physician have a common mission: to eliminate disease and suffering. Both are supported in this pursuit by a common pool of medical knowledge to which each contributes, and from which each draws in equal measure. Private practitioners of today are as much in the business of preventing disease and disability as their colleagues in public health."

As the subtitle *Principles of Prevention in the Occurrence and Progression of Disease* suggests, it is emphasized that preventive medicine does not stop with the prevention of disease alone, but concerns itself with stopping the progression of disease once it has already occurred.

The book is divided into three main parts: 1. *Prevention of Occurrence*; 2. *Prevention of Progression*; and 3. *Supporting Services for Preventive Medicine*. Under these three main headings almost every phase of public health is explored.

Under part one, *The Prevention of Occurrence*, is included the control of environmental factors as they relate to disease prevention. Everything from a safe, potable water supply to medical defense against atomic attack or natural disaster is covered. Another section of part one includes *Prophylactic Measures Against Disease*, discussing diseases according to etiology—bacterial, viral, rickettsial, etc. The rest of this section is devoted to such sub-

jects as nutrition, obesity, preventive health services in childhood, and dental health.

Part two, *Prevention of Progression of Disease*, discusses screening methods for various diseases, rehabilitation, alcoholism and drug addiction.

Part three, *Supporting Services for Preventive Medicine*, includes a variety of chapters on those aids available to the private physician; such as education, public health nursing, social work, the role of the hospital and voluntary and official health agencies.

This is an excellent reference for the busy practicing physician. A great deal of material has been condensed into a compact book which the physician can pick up and lay down at will and find much each time to satisfy him.

RAYMOND F. McATEER, M.D.

NOW OR NEVER. The Promise of the Middle Years by Smiley Blanton, M.D., with Arthur Gordon. Prentice-Hall, Inc., Englewood Cliffs, N. J., 1959. \$4.95

This is a difficult book to review, especially for a medical library. It is written for the laity and offers common sense advice on problems common to all.

Doctor Blanton writes informally, using many brief case histories as illustrations of his points. He covers many subjects such as marriage, work, money, alcohol, sex, religion, aging parents and your own old age.

He has done psychiatric counselling for more than forty years and has been associated with Norman Vincent Peale in the American Foundation of Religion and Psychiatry.

This is a book which should be available in all public libraries and one which we, as doctors, could read with profit and recommend to our patients.

AMY E. RUSSELL, M.D.

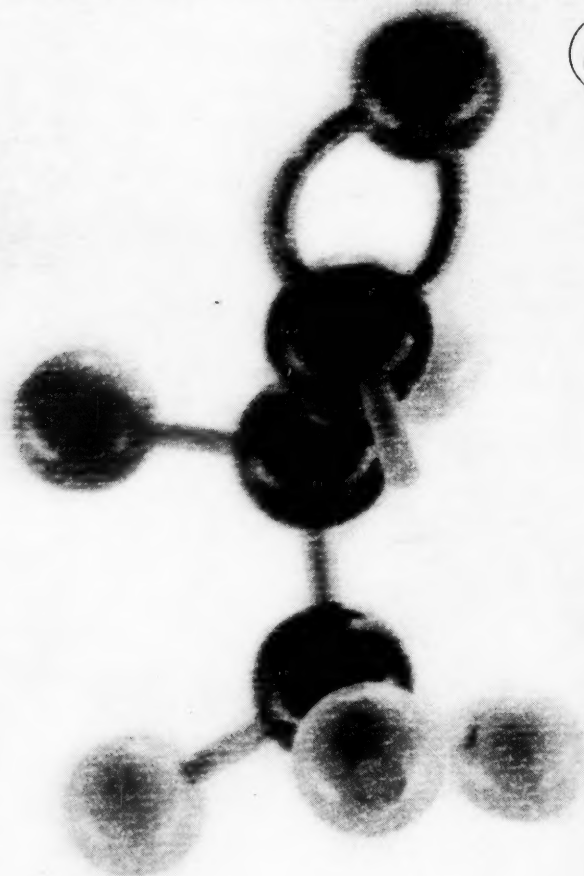
THE WASHINGTON SCENE

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pitals, 3) Federal guarantees for mortgages to finance construction of private nursing homes on a basis assuring high standards of quality in construction and operation, 4) encouragement of construction of diagnostic and outpatient facilities in rural area and the building of mental health clinics, and 5) Federal aid to cities "in more effective planning and co-ordination of health services."

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THROUGH . . .

*the Microscope***LIFE Reports on Hospital and Physician Costs**

The next few years will see hospital costs soaring, doctors' fees holding steady, and medical insurance growing until just about all of us are covered for every kind of illness and accident. These predictions, based on extensive interviews with U.S. health officials and physicians, were made by LIFE magazine in the concluding article of its four-part series on the American doctor.

The magazine said that it is probably impossible to reduce the costs of running a hospital but that experts who have studied the problem of skyrocketing prices for hospital care are searching out new paths to efficiency.

In the twenty years from 1936 to 1956 the fees charged by surgeons rose by 60 per cent, those of general practitioners 73 per cent. Neither are considered out of line with general price rises. But during the same period, hospital room rates zoomed 265 per cent, faster than almost anything else the dollar can buy. In most hospitals today, a private room costs about \$25 a day.

The LIFE study showed that hospital costs will continue to rise as the result of being forced, among other things, to pay employees better wages. The magazine pointed out that hospitals traditionally have been among the most relentless exploiters of unskilled labor, paying anywhere from \$10 to \$20 a week less than industry. A hospital strike in New York last spring uncovered the fact that many hospitals were paying their unskilled help weekly salaries of \$33.

Two other reasons for bigger bills are the demands by patients for fancier, better decorated rooms, and the fact that nursing care, laboratory and other technical services, which used to take less than half the hospital dollar, today gobble up almost three fourths of that dollar as new techniques and discoveries enlarge the opportunities for proper medical treatment.

Physician fees will probably remain steady, the magazine said. Doctors never had it so good as they do today. Thanks to a prosperous economy and the

various insurance plans, they now collect more than 90 per cent of their bills, whereas once they were lucky to collect 75 per cent. Because their services are so popular, they have more patients than in former years. Yet they make fewer night calls and spend more weekends with their families.

LIFE reports the experts as predicting continued growth of medical insurance plans until almost the entire citizenry is covered for almost every kind of treatment. The costs will rise as broader types of benefits are included, and this is expected to cause some widespread complaints from those who rebel against spending a sizable sum for protection against illnesses that may never occur.

Policy of Free Lab Exams Established by Health Department

During the depression of the thirties, the State Health Department laboratories inaugurated a program of performing diagnostic tests and procedures for the medically indigent, which had little or no public health significance.

Over the years this service has grown, until today the number of procedures performed annually is out of proportion to the number of medically indigent patients. A cursory inspection of records reveals that many procedures are being performed for private physicians on private patients when, in fact, such procedures should be performed by private clinicopathological laboratories.

To overcome this situation the following policy is established effective November 10, 1959:

Laboratory Services will be restricted to:

- (a) The medically indigent;
- (b) patients of department-sponsored clinics;
- (c) occasional disease-detection drives;
- (d) essential services for the control of communicable diseases;
- (e) consultative services to other laboratories and hospitals.

Public Health Service Reports on Children Disabilities

The extent to which acute illnesses and injuries—

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Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. 80:481 (Oct.) 1958.
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